

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25024

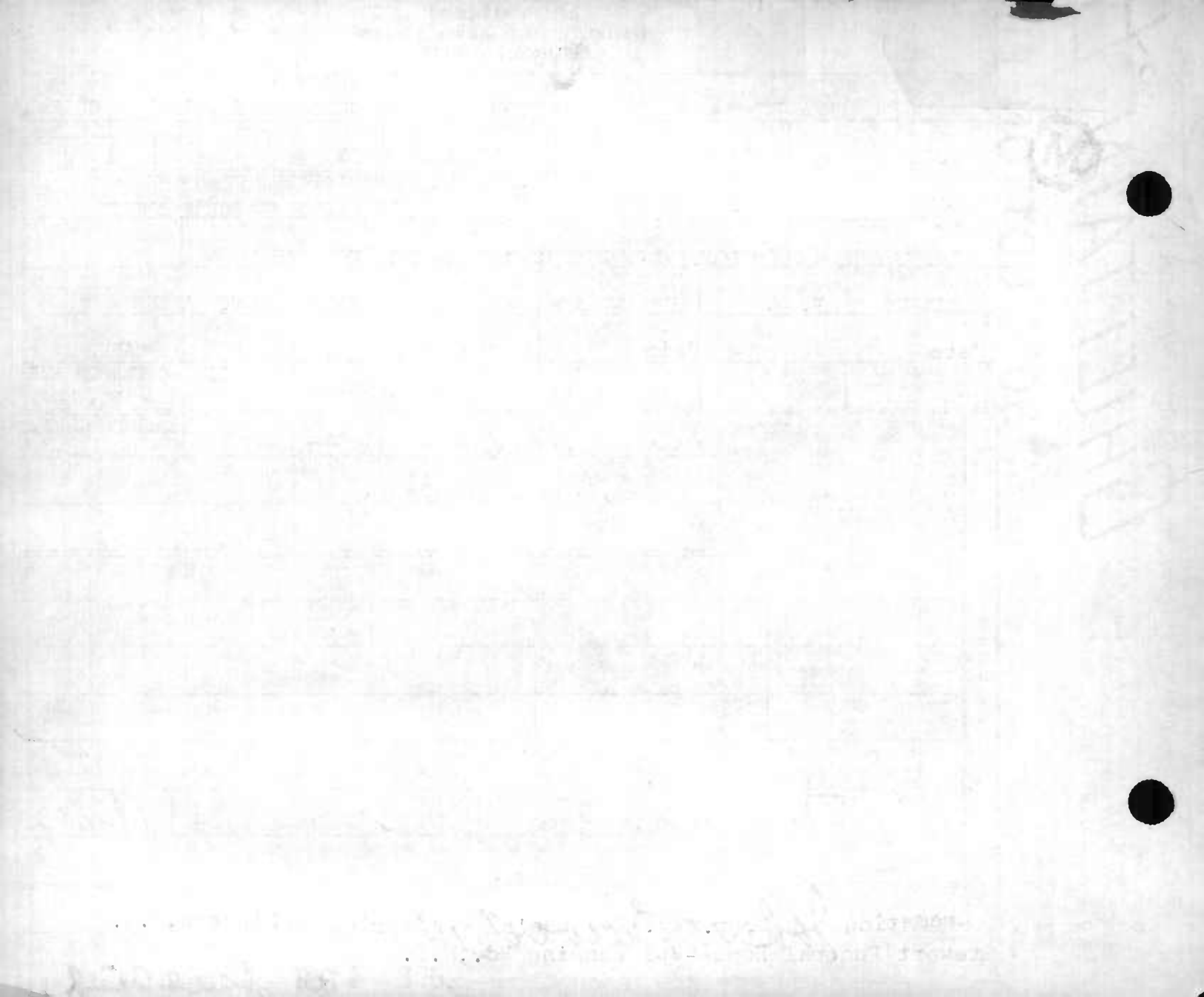
REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| ELEANOR AMBUSH | | FEMALE | | BLACK | |
| 5. DATE OF BIRTH | | 6. AGE | | 7. BIRTHPLACE | |
| JAN 30 1950 | | 33 | | MARYLAND | |
| 8. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| UNITED STATES | | PRINCE GEORGE'S COUNTY MD | | ANDREWS AFB | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| MALCOLM GROW USAF MEDICAL CENTER | | HOUSEWIFE | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | P. G. | | ANDREWS AFB | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. STREET ADDRESS | |
| Pete Cain | | MARGARET CAIN | | 2102-C TUSCON AVENUE | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 17b. SOCIAL SECURITY NO. | | 17c. INFORMANT | |
| NO | | 218-54-0316 | | FRANKLIN C AMBUSH | |
| 18. CAUSE OF DEATH | | 19. DATE OF OPERATION | | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ovarian cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | 21a. AUTOPSY? | | 21b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 22a. DATE OF OPERATION | | 22b. TIME OF INJURY | | 22c. HOW INJURY OCCURRED | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 23b. PLACE OF INJURY | | 23c. LOCATION | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | P.M. 19 | | STREET CITY OR TOWN COUNTY STATE | |
| 24. I certify that (I) (this hospital) attended the deceased from <u>25 Sept 83</u> to <u>25 Sept 83</u> , that (I) (we) last saw the deceased alive on <u>25 Sept 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death) | | 25. SIGNATURE | | 26. DATE SIGNED | |
| MARTIN RUSSO | | DEGREE | | 9/25/83 | |
| 27. PHYSICIAN'S NAME (TYPE OR PRINT) | | 28. ADDRESS | | 29. DATE REC'D. BY REGISTRAR | |
| MARTIN RUSSO | | | | 25. REGISTRAR'S SIGNATURE | |
| 30. BURIAL, CREMATION, REMOVAL | | 31. DATE | | 32. NAME OF CEMETERY OR CREMATORY | |
| Cremation | | Sept 25 1983 | | John's Crematorium, Washington, D.C. | |
| 33. FUNERAL DIRECTOR | | 34. DATE REC'D. BY REGISTRAR | | 35. REGISTRAR'S SIGNATURE | |
| Stewart Funeral Home | | 4001 Benning Rd., N.E. | | John J. Givens | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GERALD Leslie ARNOLD | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20, 1983 | | 2b. HOUR 12:40p_M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 11 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD | |
| 10. CITY OR TOWN OF DEATH LANHAM | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman | 12b. KIND OF BUSINESS OR INDUSTRY P.E.P.Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN Greenbelt | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 19 P Ridge Road Zip 20770 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joshua L. Arnold | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Marjorie Barnard | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. ? - 1964 212-32-5087 | | 17. INFORMANT ADDRESS Frances L. Arnold Same as 13e | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAINSTEM COMPRESSION 1919 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MALIGNANT GLIOMAS OF BRAIN DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/20 19 83 , to 9/20 19 83 , that (I) (we) last saw the deceased alive on 9/20 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William R. Leahy MD | | DEGREE MD | | 22c. DATE SIGNED 9/21/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM R. LEAHY MD | | 22e. ADDRESS 6525 BELCROFT RD. HYATTSVILLE MD 20782 | | | |

| | | | |
|--|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9-24-1983 | 23c. NAME OF CEMETERY OR CREMATORY Ressurrection Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md. |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons, P.A. | | ADDRESS Hyattsville, Md. | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 |
| | | 25b. REGISTRAR'S SIGNATURE John J. Casper | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) ELEANOR M ARSCOTT | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 30 83 | | 2b. HOUR 2:15P M |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR February 17, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | 7b. HOUR 2:15P M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIAGE STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH CLINTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| 13a. STATE Maryland | | 13b. COUNTY Prince George's | 13c. CITY OR TOWN Camp Springs | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME Edmin Michaels | | 15. MOTHER'S MAIDEN NAME Mary Delaney | | 13e. STREET ADDRESS 6420 Bushey Drive (20748) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT Ansell R. Arscott | |
| 16c. (IF YES, GIVE WAR OR DATES) | | 16d. (IF YES, GIVE WAR OR DATES) | | 17. ADDRESS Same As #13 A-E | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral edema & brain stem

DUE TO, OR AS A CONSEQUENCE OF

Hemorrhage

4476
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

Sp. Cerebral Endarteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a-

MEDICAL CERTIFICATION

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|---|--|--|--|
| 19a. DATE OF OPERATION 9/28 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe Cerebral Artery Disease | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/27, 1983, to 9/30, 1983, that (I) (we) lost saw the deceased alive on 9/27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE G S Grover | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G S GROVER | | 22e. ADDRESS 7501 Surra Hills Rd. # 104 | |

| | | | |
|--|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE October 3, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. Geo., Maryland |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS Old Alexander Ferry Road, Clinton, Maryland | | 25a. DATE REC'D. BY REGISTRAR OCT 6 1983 | 25b. REGISTRAR'S SIGNATURE John J. Carver |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

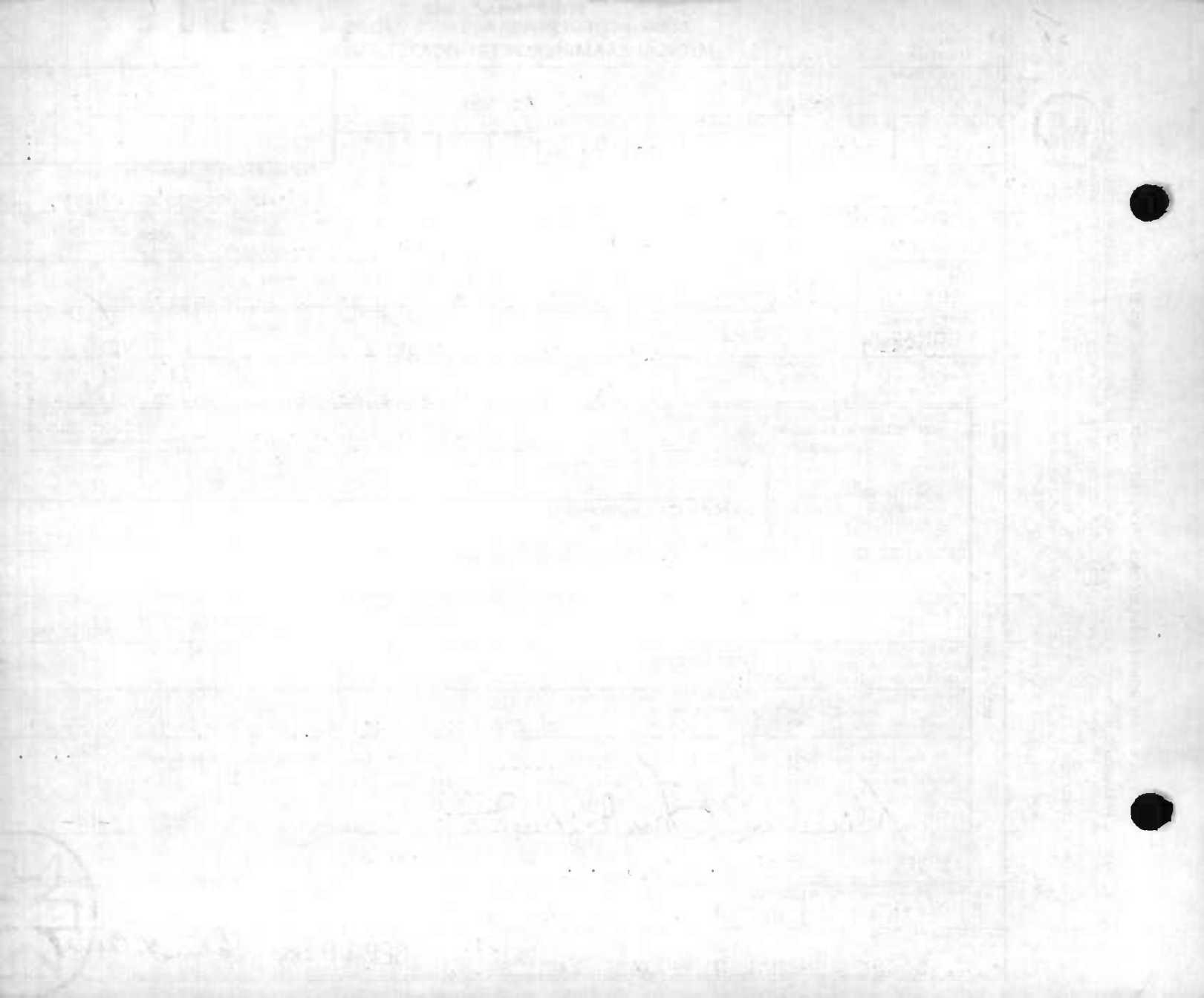
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25027

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|-------------------------|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Howard Ashmon | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 13 1983 | | | | 2b. HOUR M 2:22 P. | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 4 9 1952 | | 6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 13 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUSINESSMAN | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | | | 13b. CITY OR TOWN PRINCEGEORGE | | 13c. CITY OR TOWN LANDOVER | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 400-WILLOW HILL PL. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HOWARD | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY JONES | | | | 16. ADDRESS 400 WILLOW HILL RD. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | | | 17. INFORMANT Brenette Ashmon LANDOVER, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound of Chest (unspecified) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 1:40 P.M. 9 13 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 400 Willow Hill Rd., Lanover, Prince George's Co., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE SEPTEMBER 17, 83 | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL PARK | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, MARYLAND | |
| 24. FUNERAL DIRECTOR NAME ADDRESS W.H. BACON FUNERAL HOME 3447 14TH ST. NW WASH. D.C. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Calver</i> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25028 REG. NO. | |
|--|--|------------------|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alfred Austin | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9 27 1983 | | 2b. HOUR M 6:30 P. M. | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Jan 28 1909 | | 6. AGE (IN YEARS) LAST BIRTHDAY 74 YRS. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 27 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8128 15th Avenue | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian | | 12b. KIND OF BUSINESS OR INDUSTRY Montg County | |
| 13a. STATE Maryland | | | 13b. COUNTY Pr. George | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8128 15th Avenue, 20783 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Austin | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Tobber | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-03-4342 | | | 17. INFORMANT ADDRESS Mrs Emma Austin (Wife) 3408 Embrey St, Wheaton, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 9-28-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10-3-83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr George Md | | | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | | 24b. ADDRESS 246 N. Washington St, Rockville, Md | | | DATE RECEIVED BY REGISTRAR OCT 4 1983 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUFUS CHARLES AYLOR | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 17, 1983 | | | | 2b. HOUR 7:52 a.m. | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 21, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hosp. of Pr. Geo. Co. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY Maintenance | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Pr George | | 13c. CITY OR TOWN N. Forestville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2614 Newglen Avenue 2074/7 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Aylor | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edwina Henshaw | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WWII 224-03-3577 | | 17. INFORMANT Thelma P. Aylor | | | | ADDRESS Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of liver with metastases</i> 1552 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Revered</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the decedent from <i>June 21</i> 19 <i>83</i> to <i>Sept 17</i> 19 <i>83</i> , that (1) (we) last saw the deceased alive on <i>Sept 16</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Yes) (did) (did not) saw the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Benjamin Pecson</i> | | | | DEGREE | | | | 22c. DATE SIGNED 9.17.83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Pecson | | | | 22e. ADDRESS 6106 Old Silver Hill Rd. Suitland, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-20-83 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Vet Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham PG Md | | | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm | | | | ADDRESS Suitland, Md. | | DATE REC'D. BY REGISTRAR SEP. 22 1983 | | REGISTRAR'S SIGNATURE <i>John J. Smith</i> | | | |
| Funeral Home | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 25030 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST Joseph E. Batch | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 28 83 | | | 2b. HOUR 10:55A M | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR May 17 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) G.S.A. - Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland Prince George's | | | | | 13c. CITY OR TOWN Ft. Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 10205 Livingston Road 20744 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Batch | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Wiseman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | (IF YES, GIVE WAR OR DATES) WWII | | 16b. SOCIAL SECURITY NO. 577-20-9124 | | 17. INFORMANT 10205 Livingston Road Norma Scott Batch Ft. Washington, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema Respiratory failure</u> 4920 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>9-28</u> , 19 <u>83</u> , to <u>9-28</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9-28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>W H Furst</u> | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-28-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William K. Furst, M.D. | | | | | | 22e. ADDRESS Md. 9401 Indian Head Highway. Ft. Wasington, | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/30/83 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home | | | | | | ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | |

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J. P. Kalas

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) VICTORIA S. BAUMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR September 30, 1983 | | 2b. HOUR 9:07 A. M. | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. STATE Md. 2 0782 | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5805 Queens Chapel Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Stankiewicz | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Stahorowslca | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 039-05-6820 | |
| 17. INFORMANT ADDRESS Laurel Md. 20707 | | | 17. INFORMANT NAME Marlene A. Frazier. 332 Montgomery St., | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic Heart Disease 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years | |

| | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Parkinsons Disease | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/26 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE John W Winkler Jr | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9/30/83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN W WINKLER | | | 22e. ADDRESS 3415 HAMILTON ST HYATTSVILLE MD | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 10/6/1983 | | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Md. | | |

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C. | | | 25a. DATE REC'D. BY REGISTRAR OCT 11 1983 | | | 25b. REGISTRAR'S SIGNATURE John J. Coniff | | |
|--|--|--|---|--|--|---|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1955 Prince George, British Columbia

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 0 3 2

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MILDORED ETHEL BECKMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/11/83 | | 2b. HOUR 11:13 AM | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH APRIL 30, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. |
| 10. CITY OR TOWN OF DEATH UNIVERSITY PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6706 41ST AVENUE | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY PRINCE GEORGES 13c. CITY OR TOWN UNIVERSITY PARK | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6706 41ST AVENUE 20782 | |
| 14. FATHER'S NAME FIRST JOSEPH MIDDLE WADE LAST HAMPTON | | | 15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE BEULAH LAST SHEPHERD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 579-10-2628 | | 17. INFORMANT EDWIN J. BECKMAN | | ADDRESS SAME AS 13 HUSBAND |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Disseminatd Carcinoma (c) Primary Brain Tumor | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo 18 mo |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19/83 to 9/11/83 , that (I) (we) lost saw the deceased alive on 8/19/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE E. J. Beckman | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIN | | 22e. ADDRESS 8430 FENIX | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1983 25b. REGISTRAR'S SIGNATURE John J. Carver | | |

BP

Handwritten notes on lined paper, including a large 'D' at the top right, a date '10/10/10', and various illegible entries.

Vertical handwritten text on the right margin, possibly a date or page number.

Vertical handwritten text on the right side, possibly a date or page number.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Leon Best | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 18th., 1983 | | | | 2b. HOUR 3:45p M | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 11 1946 | | 6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NO. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY PRINCE GEORGE | | 13c. CITY OR TOWN HYATTSVILLE | | 13d. STREET ADDRESS 5809-36th AVENUE 20782 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESSIE POWELL | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT 237-68-9755 | | ADDRESS PRESTON BEST, 2111 BUNKER HILL RD., N.E., D.C. WASH., | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL HEMATOMA 8809 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH gave rise to immediate cause (a), stating the underlying cause last. (b) MISADVENTURE FALL DOWN STAIRS (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/17/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PUPP HOLE | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. ? EXACT 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) APPARENT FALL DOWN STAIRS | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOME | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (i) (this physician) attended the deceased from 9-12 1983, to 9-12 1983, that (i) (I) saw the deceased alive on 9-12 1983, and that in my opinion death occurred on the date and hour and from the causes stated above, (ii) (we) (did) (not) view the body after death. Accident | | | | | | | | | | | |
| 22b. SIGNATURE George J. Mathews, M.D. | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/18/83 | | | | | |
| 22d. PHYSICIAN'S NAME | | 22e. ADDRESS Waldorf Medical Park, Box 628, Waldorf, Md. 20601 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-29-83 | | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY | | 23d. LOCATION WHITEVILLE, N.C. COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR VANN & WILLIAMS, 4804 GA. AVE., N.W., WASH., D.C. | | | | 25a. DATE RECEIVED BY REGISTRAR SEP 26 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 8 3 2 5 0 3 4 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clotilda XXXXX M. BIRMINGHAM | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-15-83 | | 2b. HOUR 7 :20AM | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR January 14, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 65 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY P.G.Co. Government | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Pr. George's | | 13c. CITY OR TOWN Bowie | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Maguire | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Peters | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 108-16-8064 | | 17. INFORMANT ADDRESS Patrick J. Birmingham 3102 Teton Lane Bowie, MD 20715 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cancer lung</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 hr.</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-1-83</u> , 19 <u>83</u> , to <u>9/15/83</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Martin D. Wertz | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/15/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN D. WERTZ | | | | 22e. ADDRESS 7676 New Hampshire Ave Langley | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 09-19-83 | | 23c. NAME OF CEMETERY OR CREMATORY Our Lady's Ch. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Madley's Neck, St. Mary's, MD | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home | | | | 16000 Annapolis Road Bowie, Maryland 20715 | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1983 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Joan J. Carver | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Madge G. Bland | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/30/83 | | | 2b. HOUR 5:30am | |
| 3 SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10/26/14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 years | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA USA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | |
| 10. CITY OR TOWN OF DEATH Landover, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1413 BELLHAVEN DRIVE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. CITY OR TOWN Prince George Co. Landover | | 13c. STREET ADDRESS 1413 Bellhaven Drive | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Garner | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Opie GAITER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 234-40-8953 | | 17. INFORMANT ADDRESS 6414 CABIN BRIDGE COURT TOMMY BLAND, SON, SEAT PLEASANT, MD. 20027 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, but (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO OR AS A CONSEQUENCE OF (b) Bronchogenic Carcinoma 3yrs DUE TO OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1981 , 19____, to 9/30 , 19 83 , that (I) (we) last saw the deceased alive on 9-26-83 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death. | | | | | | | | | |
| 22b. SIGNATURE Donald M. Pachuta MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 9-30-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD M. PACHUTA | | | | 22e. ADDRESS 3503 N. Charles St BALD 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 10/1/83 | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLATIN CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA | | | |
| 24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | |
| 1120 CONN. AVE. N.W. #940, WASH. D.C. 20036 | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES PARKS BLEVINS | | | 2a. DATE OF DEATH MONTH DAY YEAR September 12, 1983 | | | 2b. HOUR 2:10 PM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) No. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| 13a. STATE Md. | | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Hy. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Freeman Blevins | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Welch | | | 13e. STREET ADDRESS 5114-Edmonston Rd. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. WW II | | 17. INFORMANT Thelma Blevins (Wife) | | ADDRESS Same as above | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) *Cerebral aneurysm of left lung*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
immediate

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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

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| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>8-18-83</u> to <u>9-12-83</u> , that (I) (we) lost saw the deceased alive on <u>9-9-83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-13-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. RICHARD LILLY, MD. | | | | 22e. ADDRESS 5804 Baltimore Ave. Hyattsville, Md. 20781 | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-17-83 | | 23c. NAME OF CEMETERY OR CREMATORY Blevins Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Whitetop Va. | |
|---|--|-----------------------------|--|---|--|---|--|

| | | | | | |
|--|--|---|--|--|--|
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1983 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |
|--|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 calendar days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| <div style="display: flex; justify-content: space-between;"> <div> <p>FOR 1 - STATE REGISTRAR</p> </div> <div> <p>STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH</p> </div> <div> <p>8 3 2 5 0 3 7</p> </div> </div> | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| <div style="display: flex; justify-content: space-between;"> FIRST MIDDLE LAST </div> <p>LORRAINE MOORE BLODGETT</p> | | | | | | <div style="display: flex; justify-content: space-between;"> MONTH DAY YEAR </div> <p>SEPTEMBER 21, 1983</p> | | | | <p>10:23p.m.</p> | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS | |
| FEMALE | | WHITE | | <div style="display: flex; justify-content: space-between;"> MONTH DAY YEAR </div> <p>MARCH 24 1916</p> | | 67 | | <div style="display: flex; justify-content: space-between;"> MONTHS DAYS </div> | | <div style="display: flex; justify-content: space-between;"> HOURS MIN. </div> | |
| 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MASSACHUSETTS | | UNITED STATES | | <div style="display: flex; justify-content: space-between;"> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED </div> | | PRINCE GEORGE'S COUNTY | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| ANDREWS AFB | | MALCOLM GROW USAF MEDICAL CENTER | | | | HOUSEWIFE | | | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| VIRGINIA | | FAIRFAX | | SPRINGFIELD | | <div style="display: flex; justify-content: space-between;"> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO </div> | | 7429 FLORA STREET | | 99999 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> FIRST MIDDLE LAST </div> <p>DENNIS MAHONEY</p> | | | | <div style="display: flex; justify-content: space-between;"> FIRST MIDDLE LAST </div> <p>Mary Not Known</p> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| <div style="display: flex; justify-content: space-between;"> (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) </div> <p>NO</p> | | | | 028-12-4461 | | REXFORD J. BLODGETT 7429 FLORA ST., SPRINGFIELD, VA | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> | | | | | | | | | | | |
| 5724 DUE TO, OR AS A CONSEQUENCE OF GASTROINTESTINAL BLEED | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div> <p>(b) <u>gastrointestinal bleed</u></p> </div> </div> | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>(c) <u>hepatorenal syndrome</u></p> </div> <div> <p>DUE TO, OR AS A CONSEQUENCE OF HEPATORENAL SYNDROME</p> </div> </div> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </div> | | <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> YES <input type="checkbox"/> NO </div> | |
| 21a. ACCIDENT WAS UNDERLYING | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED | | | |
| <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) </div> | | | | <div style="display: flex; justify-content: space-between;"> HOUR A.M. MONTH DAY YEAR </div> <p>P.M. 19</p> | | | | <p>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)</p> | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | | | 21f. LOCATION | | | |
| <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK </div> | | | | <p>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</p> | | | | <div style="display: flex; justify-content: space-between;"> STREET CITY OR TOWN COUNTY STATE </div> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11 SEPT</u> , 19 <u>83</u> , to <u>22 SEPT</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>22 SEPT</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| <p>Beth Haselhorst</p> | | | | | | | | <div style="display: flex; justify-content: space-between;"> <input checked="" type="checkbox"/> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN </div> | | 24 Sept 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | | |
| BETH HASELHORST MD | | | | | | MALCOLM GROW USAF MED CEN AAFB, MD 20331 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | |
| Cremation | | | | 9-23-83 | | Cedar Hill Crematory | | | | <div style="display: flex; justify-content: space-between;"> CITY OR TOWN COUNTY STATE </div> <p>Suitland PG Md</p> | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert E. Wilhelm Funeral Home | | | | | | SEP 26 1983 | | <p>John J. Gault</p> | | | |
| Suitland, Md | | | | | | | | | | | |

20% COLICM

WILEY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 13 shows any injury, or other traumatic event, the medical examiner must be notified at once. 9/25/83 Medical Examiner Notified and did approve, CHG.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25038 | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME [TYPE OR PRINT] FIRST MIDDLE LAST Ellamae R. Blythe | | | | 2b. HOUR 9:02P.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 18, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY Pr. Geo's | | 13c. CITY OR TOWN Riverdale | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jacob Rall | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Bunting | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16a. SOCIAL SECURITY NO 165 36 1762 | | 17. INFORMANT ADDRESS Ella L. McBride Same as #13 (Daughter) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic disease</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic restrictive lung disease congestive heart failure</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 19 81</u> to <u>JULY 7 19 83</u> , that (I) (we) last saw the deceased alive on <u>JULY 7 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (d) (d) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Gerardo M. Gacad</u> DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept 26, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gerardo M. Gacad, M.D. | | | | 22e. ADDRESS 6492 Landover Rd. Landover, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Cremation | | 23b. DATE 9/28/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE SEP 27 1983 <u>John J. Connelley</u> | | | |

Medical Examiner Notified & Released Case

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ARTHUR CLARENCE BOST | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-12-83 | | 2b. HOUR 9:56AM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR April 1, 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Texas | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD. | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OR FIRST PART OF WORKING LIFE) Plumber | | 12b. KIND OF BUSINESS OR Plumbing Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. CITY OR TOWN Prince Geo. | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 20712 3153 Queens Chapel Rd. #202 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Allison Bost | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 578 09 5917 | | 17. INFORMANT ADDRESS Ailene M. Bost Same as #13 (Wife) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis, Adult Respiratory Distress 4860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia Urinary Tract Infection DUE TO, OR AS A CONSEQUENCE OF (c) Fracture of left hip | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | |
| 19a. DATE OF OPERATION 9-7-83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture left hip | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9-5-83 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Fall from bed | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET RAILROAD, OFFICE, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3154 Queens chapel road #202 P.G. Md | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-5-83 19 83 , to 9-12 19 83 , that (I) (we) last saw the deceased alive on 9-12 19 83 , and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural | | | | | | |
| 22b. SIGNATURE R. P. Tripathi | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-12-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. P. TRIPATHI | | 22e. ADDRESS 3503 Perry St. Mt. Rainier. MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/15/83 | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE De. J. Connel | | |

Great Escalator & Elevator Building, Inc.



CHEVERLY

PRINCE GEORGE'S GENERAL HOSPITAL

Princess

PRINCE GEORGE'S

Washington Co.

State Health Department

Unknown

See on only, please. No. 1000 (1000)



2000-10-10

1000-10-10

Washington State Health Department

Washington State Health Department

Serial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME [TYPE OR PRINT] | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| EDNA ADAIR BRACKEEN | | | SEPTEMBER 4 83 | | | 0254 M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | | | 7. BALTIMORE CITY OR COUNTY OF DEATH | | |
| FEMALE | WHITE | JULY 23 1902 | 81 | | | PRINCE GEORGE'S COUNTY MD. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KINDS OF BUSINESS OR INDUSTRY | | |
| TEXAS | UNITED STATES | | HOUSEWIFE/MOTHER | | | HOME | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 13a. STREET ADDRESS | | | 13b. INSIDE CITY LIMITS? | | |
| ANDREWS AFB | MALCOLM GROW USAF MEDICAL CENTER | | 113 SOUTH FORT ST 99999 | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | |
| VIRGINIA | SHENANDOAH | STRASBURG | MINNIE MARGARET LANKFORD | | | No | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | |
| JAMES ROBERT ADAIR | 457-32-0342 | | JOHN F KUZNICKI, STRASBURG VA 22657 | | | PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>13 JUL</u> , 19 <u>83</u> , to <u>04 SEP</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>04 SEP</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Joseph D. Dye</u> | | | | | | DEGREE MD | | 22c. DATE SIGNED 4 Sep 83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH D. Dye | | | | | | 22e. ADDRESS MALCOLM GROW USAF MED CEN AAFB, MD 20331 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE September 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Rosemound Cemetery Assoc. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hunt County, Texas | |
| 24. FUNERAL DIRECTOR Lee Funeral Home, Inc. NAME ADDRESS 6633 Old Alexander Ferry Road, Clinton, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u> |

THE

BOOK COLLECTION

1933

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 16 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medo notified and approved

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 25041 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leroy E. Brashears | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 26, 1983 | | | |
| 3. SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 3 13 22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | |
| 10. CITY OR TOWN OF DEATH Marlow Hgts. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4304 Riviera Ct. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't. | |
| 13a. STATE Maryland | | 13b. COUNTY Pr. George | | 13c. CITY OR TOWN Marlow Hgts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leroy W. Brashears | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie T. Gatley | | 13e. STREET ADDRESS 4303 Riviera Ct. 20748 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 578-03-4757 | | 17. INFORMANT ADDRESS Maxine Brashears same as item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Sclerotic Cardiac Vascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-23 1983 to Aug 22 1983 , that (I) (we) last saw the deceased alive on 8-23 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John F. Shay | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/28/83 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John F. Shay, M.D. | | | | 22a. ADDRESS 5509 Silver Hill Rd. Suitland, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/29/83 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md. | |
| 24. FUNERAL DIRECTOR NAME G.P. Kalas | | | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | | |
| ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | 25b. REGISTRAR'S SIGNATURE Sam J. Conner | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and deliver them to the funeral director within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B, show only injury, or other traumatic event, or medical examiner must be called at once.

| Form #16b, Film G585 11/3/83 | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 25042 | |
|---|---|--|---|---|--|
| 1. STATE REGISTRAR | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FRANK HENRY BREAU LT SR | | 2a. DATE OF DEATH MONTH DAY YEAR 28 SEP 83 | | 2b. HOUR 2000p | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR MAY 15, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S | |
| 10. CITY OR TOWN OF DEATH ANDREWS AFB | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MED CTR | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPPLY | | 12b. KIND OF BUSINESS OR INDUSTRY MILITARY |
| 13a. STATE DELAWARE | | 13b. COUNTY KENT | 13c. CITY OR TOWN DOVER | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME EDWARD BREAU LT | | 15. MOTHER'S MAIDEN NAME GERTRUDE LIVIE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF NOT NEW OR RE-ENTERED) 1942-1963 263-09-8855 | | 17. INFORMANT ADDRESS MARY BREAU LT 416 DOGWOOD AVE DOVER DE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 28 Sept , 19 83 , to 28 Sept , 19 83 , that (I) (we) last saw the deceased alive on 28 Sept , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kurt Harding | | DEGREE DO ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 28 Sep 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KURT HARDING | | 22e. ADDRESS MALCOLM GROW USAF MED CTR, ANDREWS AFB, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 10/3/83 | | 23c. NAME OF CEMETERY OR CREMATORY Abingdon Nat'l Cem | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon Va | | 23e. DATE RECEIVED BY REGISTRAR 10 OCT 03 1983 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Edward S. Baranov | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | | | 83 25043 | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | |
| LUTHER | | BROOKINS | | 9/19/83 845 M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS | |
| MALE | BLACK | 8/10/04 | | 79 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Alabama | U.S.A. | | | PRINCE GEORGE MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| CLINTON | CLINTON CONV. CENTER | | Railroad Chef | | Private |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE D.C. | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | |
| WASHINGTON D.C. | | Washington | | 4333 4th ST. SE. 99999 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | |
| Luther Brookins | | | Bama Marbury | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 719-07-0328 | | Washington, D. C. 20009 Barbara A. Chinn, niece, 2480 16th St. NW, 632 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anemia due to Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Anemia - cardiac Anemia</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>83</u> , to <u>9/19</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/19</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| KEEP NOTARIAL | | 4235 26th Ave NW 20746 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Sept. 23, 83 | | Lincoln Memorial | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | REGISTRAR'S SIGNATURE | |
| McGuire Funeral Service, Inc. | | 7400 Georgia Ave. NW Washington, DC 20012 | | SEP 26 1983 John J. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | |
| 1. DECEASED NAME FIRST MIDDLE LAST William L. Brooks | | | September 25 1983 | | 2b. HOUR 7:55a M |
| 3. SEX male | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR June 4 1908 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | |
| 10. CITY OR TOWN OF DEATH Lanham | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors'Hosp. of P.G. County | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | 12b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 13a. STATE Wash., D.C. | | 13b. COUNTY P.G. County | 13c. CITY OR TOWN Lanham | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Isaac Brooks | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Florence Penney | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-12-3931 | | 17. INFORMANT ADDRESS Dorothy Hall, (Daughter) same as #13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 5860 (b) Sepsis, Shock, Acute renal failure, Intestinal obstruction? (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) chronic and acute megacolon - | | | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-24-83 to 9-25-83, that (I) (we) lost above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE M.D. | | 22c. DATE SIGNED 9-25-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES M.D. | | 22e. ADDRESS 5632 Annapolis Rd #14 Bladensburg, Md-20701 | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 10-1-83 | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem. | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) Sutland, Md. |
| 24. FUNERAL DIRECTOR Vann & Williams, 4804 Ga. Ave., N.W., Wash., D.C. | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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RECEIVED
JAN 10 1962
U.S. DEPARTMENT OF AGRICULTURE

CHARLES W. WILSON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) OLIVER BROWN | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 25 1983 | | | | 2b. HOUR 8:30 PM | | | |
| 3. SEX M | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR MARCH 8 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C. | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MD | | | | | |
| 10. CITY OR TOWN OF DEATH LANHAM, Maryland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Special Police | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Bowie | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8030 CHESTNUT AVENUE | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Brown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Carter | | | | 16. ADDRESS Mrs. Elizabeth Brown-wife-8030 Chestnut Avenue, Bowie, Maryland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | 16b. SOCIAL SECURITY NO. 577 01 7679 | | | | 17. INFORMANT Mrs. Elizabeth Brown-wife-8030 Chestnut Avenue, Bowie, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) Pericardial Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4140 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 20 yrs 10 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Tuberculosis, Scurvy, Degenerative Joint Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 25 19 82 to Sept 25 19 83 that (I) (we) last saw the deceased alive on 9/25 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Henry A. Wise Jr | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry A. Wise Jr | | | | 22e. ADDRESS Lanham, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE September 29, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery, Washington, D.C. | | 23d. LOCATION CITY, C.T., IN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR Stewart Funeral Home | | | | 4001 Benning Rd., N.E. | | | | DATE REC'D. BY REGISTRAR OCT 4 1983 | | REGISTRAR'S SIGNATURE John J. Connel | |

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THE UNIVERSITY OF CHICAGO
LIBRARY

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Chicago, Illinois
February 1, 1900
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 28th inst. in relation to the matter of the Chicago and North Western Railway Company, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
J. M. [Signature]

Enclosed for you are two copies of the report of the Chicago and North Western Railway Company, which will give you the details of the matter.

I am, Sir, very truly,
Your obedient servant,
J. M. [Signature]

Very truly,
J. M. [Signature]



CHICAGO, ILL. FEB 1 1900

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

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20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25045

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------|--|--|--|--|--|---|--|--|--|---|--|-------------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST <i>Mary</i> | | MIDDLE <i>Elizabeth</i> | | LAST <i>Browning</i> | | 2a. DATE KNOWN OF DEATH | | MONTH <i>9</i> | | DAY <i>4</i> | | YEAR <i>83</i> | | 2b. HOUR <i>1.22</i> | | | |
| 3. SEX <i>F</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH MONTH <i>April</i> DAY <i>20</i> YEAR <i>1903</i> | | 6. AGE (IN YEARS) LAST BIRTHDAY <i>80</i> YRS. | | IF UNDER 1 YR. MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | | 7c. DATE PRONOUNCED DEAD MONTH <i>9</i> DAY <i>4</i> YEAR <i>83</i> | | 2d. HOUR <i>1.22</i> | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Hyattsville</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2223 Charleston Pl.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Prince George's</i> | | | | 13c. CITY OR TOWN <i>Hyattsville</i> | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS <i>2223 Charleston Pl.</i> | | | |
| 14. FATHER'S NAME FIRST <i>Adam</i> MIDDLE <i>McKendree</i> LAST <i>Bowman</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Jemima</i> MIDDLE <i>Elizabeth</i> LAST <i>Boyer</i> | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>212-65-2238</i> | | | | 17. INFORMANT ADDRESS <i>8440 Main St. Damascus, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 4148 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Said A. DARE MD</i> | | | | TITLE (SPECIFY) <i>Deputy</i> | | | | MEDICAL EXAMINER | | | | DATE SIGNED <i>9-4-83</i> | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>5632 annapolis Rd</i> | | | | ADDRESS <i>Bladensburg MD 20710</i> | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | 23b. DATE <i>Sept. 7, 1983</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Damascus Meth.</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Damascus, Montgomery, Md.</i> | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Olin L. Molesworth, P.A., Damascus, Md.</i> | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 8 1983</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>Sam J. Gault</i> | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HERMON JEFFERSON BROYLES, SR. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 27, 1983 | | | 2b. HOUR 3:30P M | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR April 6, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Mason-Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY Brick Mason | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George 13c. CITY OR TOWN Temple Hills | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5105 South Barnaby Road 20748 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST J. Franklin Broyles | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Smith | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 231-07-7397 | | 17. INFORMANT ADDRESS V. Estelle Layser 4815 Temple Hills Rd. Temple Hills, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4920 respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) aspirated pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) myelipnea PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: prolonged care | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/17 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 9/17 , 19 83 , to 9/27 , 19 83 , that (b) (we) last saw the deceased alive on 9/27 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/28/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D. | | | | | 22e. ADDRESS 831 University Blvd.E, Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/30/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | | | |
| 25. REGISTRAR'S SIGNATURE John J. Calver | | | | | | | | | |

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 29. Virginia Prince George (1710-1711)
 30. Virginia Prince George (1710-1711)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

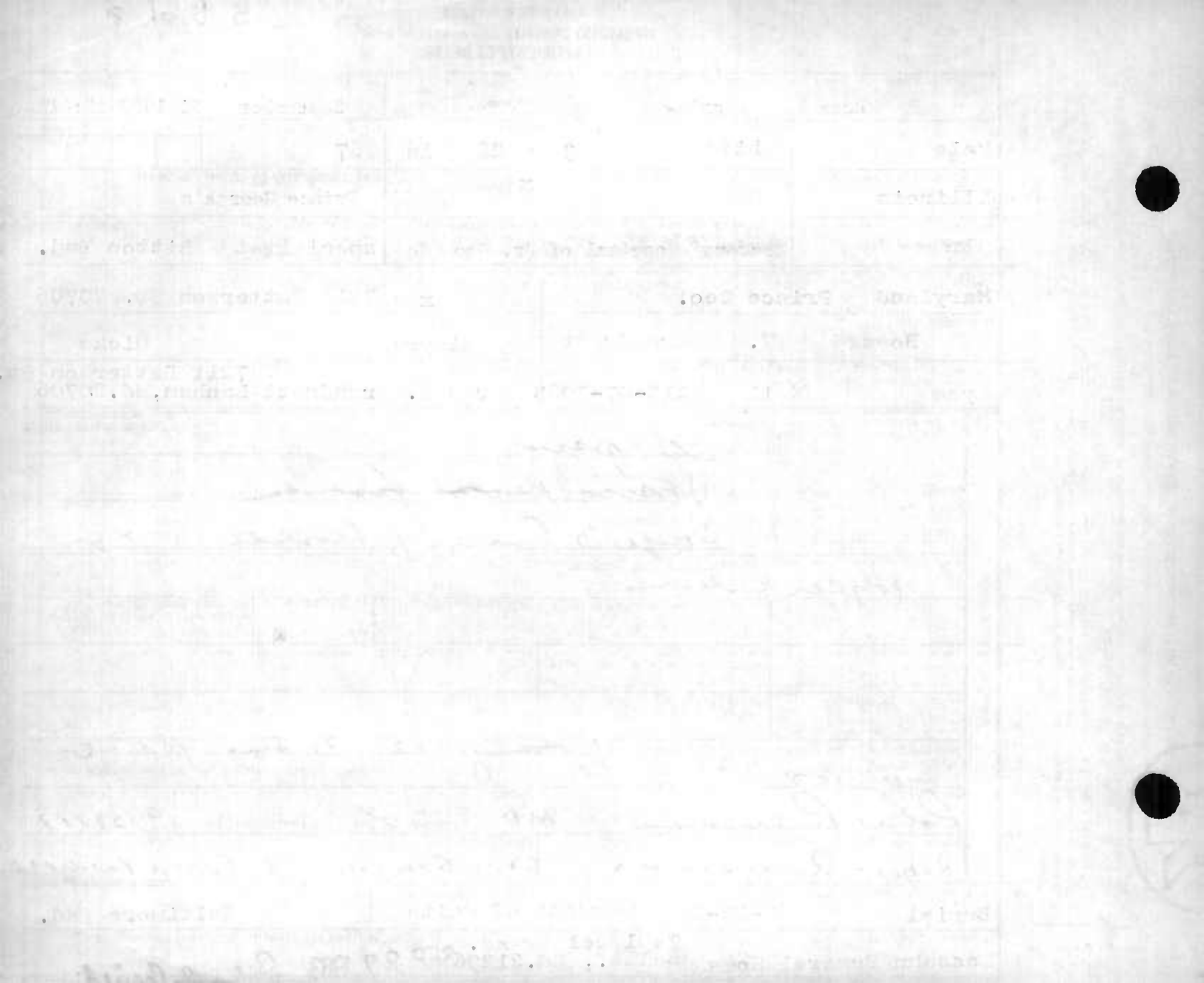
| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ross Charles BRUNDRETT | | | 2a. DATE OF DEATH MONTH DAY YEAR September 21, 1983 | | | 2b. HOUR 12:41A _M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 28 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo Co | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) specialist | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 7211 Patterson St. 20706 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Howard W. Brundrett | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Simyra Dicks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WW 11 | | 17. INFORMANT ADDRESS 7211 Patterson St. Sarah E. Brundrett Lanham, Md. 20706 | | | |

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|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> 1850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Vesico-Rectal fistula</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stage D Cancer of Prostate</u> 4 yrs. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hyperkalemia</u> | | | | | |
| 19a. DATE OF OPERATION <u>9/20</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1 Jan</u> , 19 <u>83</u> , to <u>31 Sept</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/20</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Robert Ruderman</u> | | DEGREE MD | | 22c. DATE SIGNED 9/21/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Ruderman, M.D. | | 22e. ADDRESS 6201 Greenbelt Rd, College Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-23-83 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | |
| 23d. LOCATION CITY OR TOWN Baltimore | | 23e. COUNTY Md. | | 23f. STATE | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home | | 7401 Belair Rd. Balto., Md. 21236 | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1983 | |
| 25b. REGISTRAR'S SIGNATURE <u>John A. Baird</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

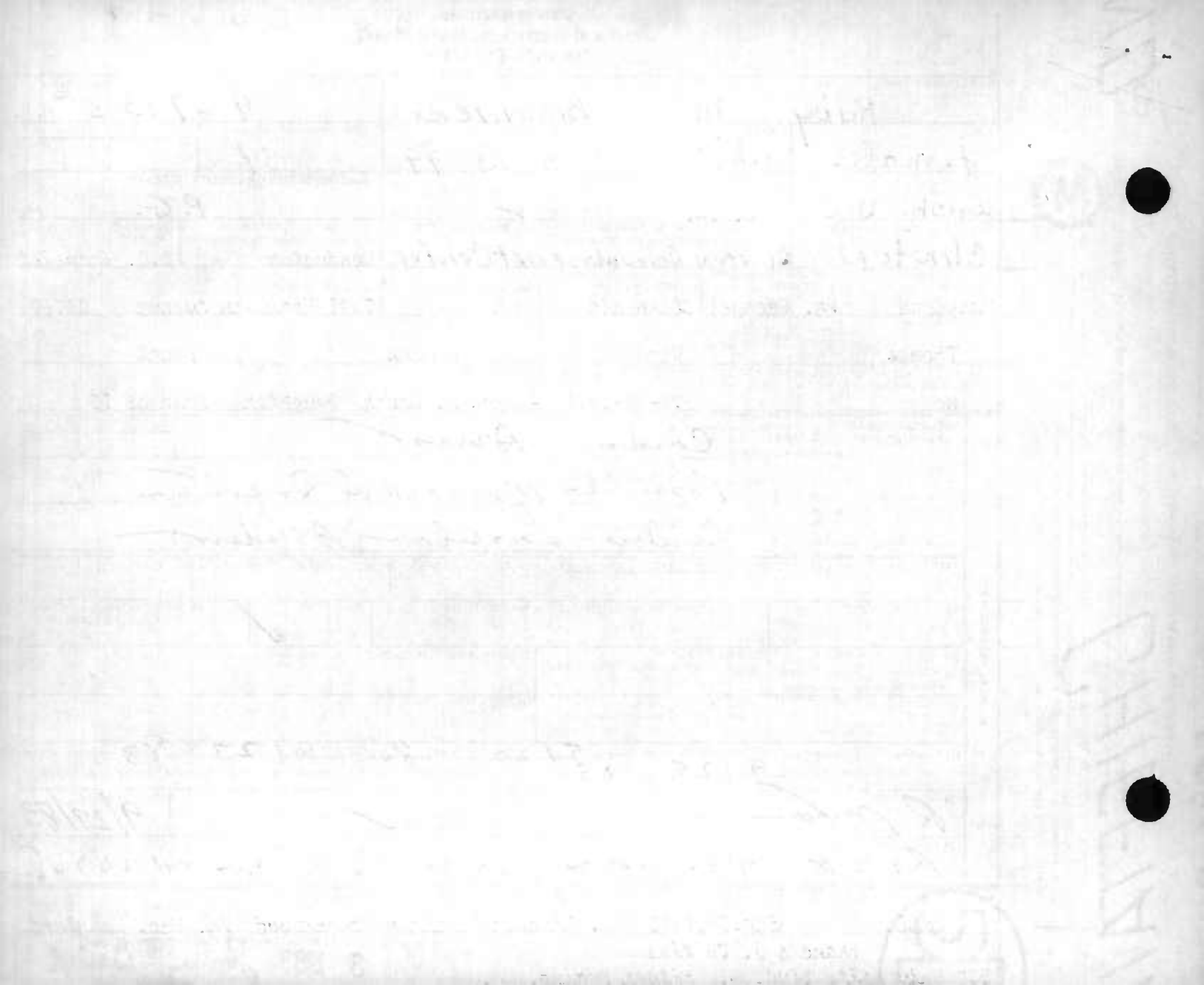
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|-----------------------------------|---|---|--|---|
| 1. FOR STATE REGISTRAR | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruby M BRUNNER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 27 83 | |
| 3. SEX Female | | | | | 2b. HOUR 5¹⁵ A.M. | |
| 4. RACE white | | | | | 5. DATE OF BIRTH MONTH DAY YEAR 3 13 99 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH P.G. MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Convalescent Center | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor | | | | | 12b. KIND OF BUSINESS OR INDUSTRY D.C. Transit | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Pr. Georges | |
| 13c. CITY OR TOWN Glenn Dale | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Dean | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marian Hazel | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 578-22-6041 | |
| 17. INFORMANT Amanda M. Bauer | | | | | ADDRESS Daughter Same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 Immediate Cause (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Possible Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral - Vascular Bleeding | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/20 19 80 to 9/27 19 83 that (I) (we) lost saw the deceased alive on 9/25 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE R. M. Brunner | | | | | 22c. DATE SIGNED 9/27/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. E. Z. A. M. O. S. T. A. N. | | | | | 22e. ADDRESS 4235 2A St. Ann Rd 20748 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sep. 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Maryland |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 3 1983 | |
| 25b. REGISTRAR'S SIGNATURE John J. Collins | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HOWARD BRYANT | | | | 2a. DATE OF DEATH MONTH 9 DAY 17 YEAR 83 | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH 4 DAY 15 YEAR 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Mo. Hosp. Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE MD. | | 13b. COUNTY PRINCE GEORGE | | 13c. CITY OR TOWN FORESTVILLE | | 13e. STREET ADDRESS 3203 WALTERS, LANE | |
| 14. FATHER'S NAME FIRST JESSIE MIDDLE BRYANT LAST BRYANT | | | | 15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. NO | | 17. INFORMANT ADDRESS WIFE ELIZABETH BRYANT SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CARDIOMYOPATHY ? (c) CARDIOMYOPATHY ? DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CIRRHOSIS OF LIVER WITH BLEEDING VARICES-RENAL INSUFF. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-15-83 , 19 83 , to 9-17 , 19 83 , that (I) (we) last saw the deceased alive on 9-17 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael G. Seremetis MD | | | | DEGREE MD | | 22c. DATE SIGNED 9-18-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Seremetis | | | | 22e. ADDRESS 3921 Ferrara Park Silver Spring 20906 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-22-83 | | 23c. NAME OF CEMETERY OR CREMATORY PORT LINCOLN | | 23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P.G. MD. | |
| 24. FUNERAL DIRECTOR NAME W.H. BACON ADDRESS 3447-14th ST. NW, | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1983 | | 25b. REGISTRAR'S SIGNATURE John G. ... | |

BP

RECEIVED
JUL 10 1964

Handwritten notes and a table on lined paper. The table has several columns and rows, with some entries filled in. The handwriting is cursive and somewhat faded.

Handwritten notes and a table on lined paper. The table has several columns and rows, with some entries filled in. The handwriting is cursive and somewhat faded.



CHIEF

20% COLLECT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

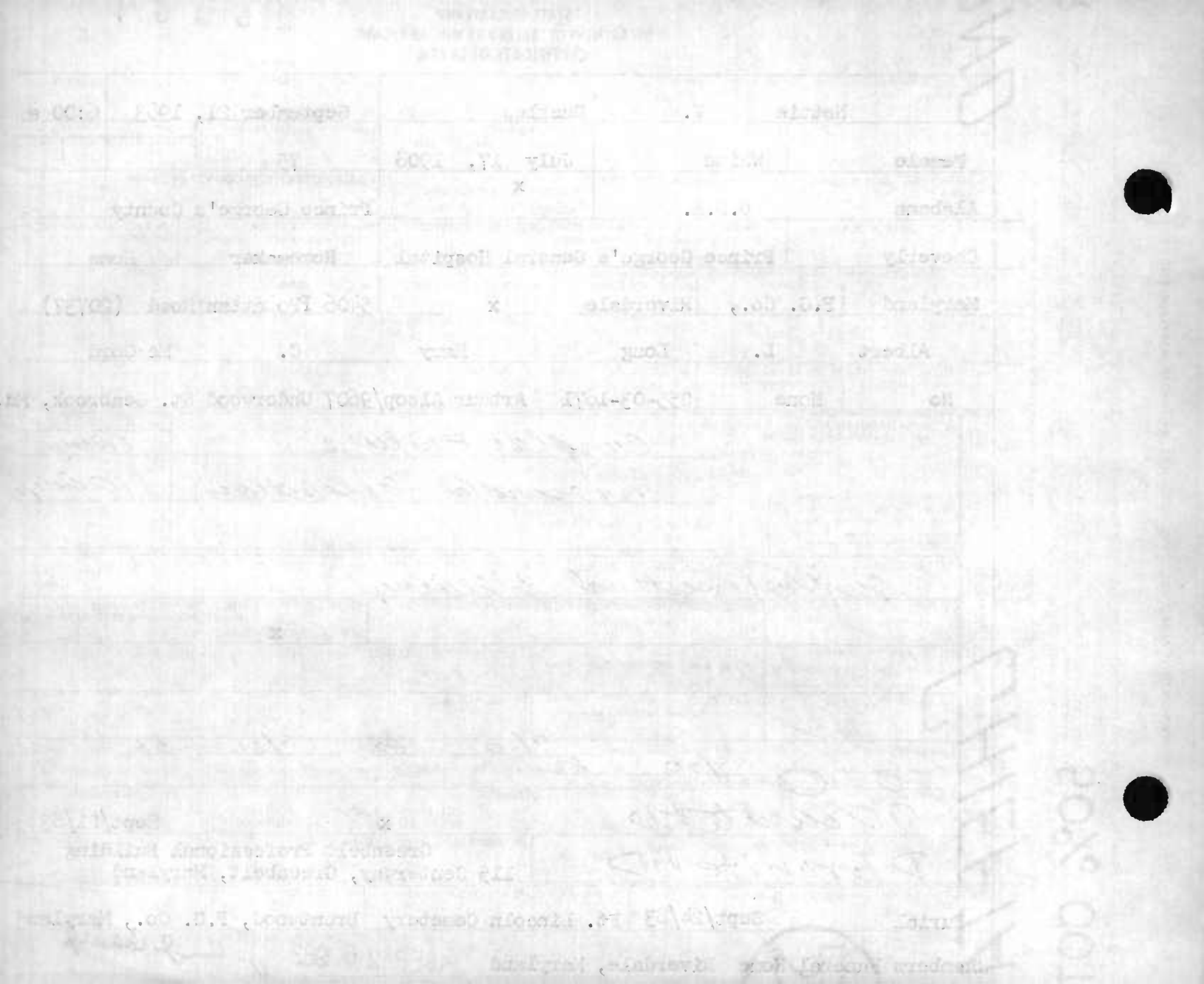
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Nettie V. Buckles | | | 2a. DATE OF DEATH MONTH DAY YEAR September 21, 1983 | | | 2b. HOUR 6:00 PM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 17, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. Co., | | 13c. CITY OR TOWN Riverdale | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert L. Long | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Mc Cord | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | | 17. INFORMANT ADDRESS Arthur Alsop/9607 Underwood St. Seabrook, Md | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) 1 Day 10 Days | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: gastrointestinal bleeding | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10 19 83 , to 9/21 19 83 , that (I) (we) lost saw the deceased alive on 9/20 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE D. Granite MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept/21/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Granite MD | | | | 22e. ADDRESS Greenbelt Professional Building 115 Centerway, Greenbelt, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept/24/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Co., Maryland | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Riverdale, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 26 1983 John J. Smith | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | |
|---|--|--|---|---|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) JUDITH ANN BURGIN | | | 2a. DATE OF DEATH MONTH DAY YEAR September 19, 1983 | | 2b. HOUR 8:40 P.M. | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 14 1941 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | | |
| 10. CITY OR TOWN OF DEATH LAUREL | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD | | |
| 13a. STATE MARYLAND | | 13b. COUNTY PG. | | 13c. CITY OR TOWN LAUREL | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOE G. MOPPS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALMA - HYLANDS | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRANCH MANAGER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 372-38-1161 | | 17. INFORMANT ADDRESS JEFFREY BURGIN Same as #13E | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac Arrest**
1990
DUE TO, OR AS A CONSEQUENCE OF
(b) **Septic Shock**
DUE TO, OR AS A CONSEQUENCE OF
(c) **Carcinomatous, diffuse**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **1990**

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-16-83 to 9-19-83 , that (I) (we) last saw the deceased alive on 9-19-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE William A. Warner | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-19-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. WARREN | | | | 22e. ADDRESS 301 Prince George St Laurel, Md 20707 | | | |

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|--|--|----------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 21 SEPT 1983 | | 23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PG. MD | |
| 24. FUNERAL DIRECTOR FLECK FUNERAL HOME INC. NAME ADDRESS 7601 SANDY SPRING RD. LAUREL MD. 20707 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, unless it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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July 1st 1891

July 2nd 1891

July 3rd 1891

July 4th 1891

July 5th 1891

July 6th 1891

July 7th 1891

July 8th 1891

July 9th 1891

July 10th 1891

July 11th 1891

July 12th 1891

July 13th 1891

July 14th 1891

July 15th 1891

July 16th 1891

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Beatrice Belle Shawkey Burke | | | 20. DATE OF DEATH MONTH DAY YEAR 9 24 83 | | | 26. HOUR 5:39A M | | | |
| 3. SEX Female | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 14, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co MD. | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Md. Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistics Clerk U.S. Gov't | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Charles | | 13c. CITY OR TOWN Indian Head | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 32 Jonquil Place 20640 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Howard J. Shawkey | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Eddy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-03-5136 | | 17. INFORMANT ADDRESS 603 Indian Head Ave. Mary L. Burke Indian Head, Maryland | | | | | |

| | |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Biventricular congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive cardiovascular disease | |
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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) COPD, DM | |
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|------------------------|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|--|--|--|--|

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
|---|--|---|--|---|--|--|--|

| | | | | | |
|--|--|--|--|---|--|
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
|--|--|--|--|---|--|

| | |
|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 21, 1983 , to Sept 24, 1983 , that (I) (we) lost saw the deceased alive on Sept 23, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
|--|--|

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|---|--|--------|--|------------------------------------|--|
| 22b. SIGNATURE Y. Kaccin - Azer | | DEGREE | | 22c. DATE SIGNED 9-24-83 | |
|---|--|--------|--|------------------------------------|--|

| | | | |
|---|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUBICA KACIR-AZER | | 22e. ADDRESS 912 Piscataway Rd, Clinton, Md. | |
|---|--|--|--|

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|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-27-83 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens Waldorf, Charles, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
|---|--|-----------------------------|--|---|--|--|--|

| | | | | | |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |
|--|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or contacted.

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CHITREX



Wooltex, Home, Belfast, Ireland and
9-7-55 Textile Research, Belfast, Ireland

FOR
1- STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|-------------------------|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Cynthia L. Burkey | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 19 1983 | | | 2b. HOUR P. M. 9:00 |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1961 | 6. AGE (IN YEARS) LAST BIRTHDAY 22 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 20 1983 | 7d. HOUR P. M. 9:00 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, Md. |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5100 Kenilworth Ave., #5 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Silver Spring | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 8656 Piney Branch Road 20901 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James A. Burkey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Mahaney | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-84-0508 | | 17. INFORMANT ADDRESS James A. Burkey Father Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cocaine intoxication 3042 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth M.D. | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | DATE SIGNED 9-21-83 |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS 111 Penn Street | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sep. 23, 1983 | 23c. NAME OF CEMETERY OR CREMATORY George Washington Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Pr. Geo. Md. | |
| 24. FUNERAL DIRECTOR'S NAME Francis J. Collins | | | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | 25b. REGISTRAR'S SIGNATURE J. J. Collins |
| 500 Univer. Blvd., W. Silver Spring, Md. 20901 | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The information obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the health department. Pages 3 and 4 should be filed with the funeral home. Pages 5 and 6 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 25055 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST ETHEL | | MIDDLE S. | | LAST BURR | | 2a. DATE OF DEATH MONTH DAY YEAR September 5, 1983 | | 2b. HOUR 2:05 M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 29, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Investigator | | 12b. KIND OF BUSINESS OR INDUSTRY TREASURY DEPT. | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN SILVER SPRING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1016 FENWICK LANE 20910 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Shipley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gannon | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 577-60-1419 | | 17. INFORMANT SON DAVID R. BURR | | 17a. ADDRESS 13705 FLINT ROAD ROAD ROCKVILLE, MD. 20853 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED ARTERIOSELEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CEREBROVASCULAR ACCIDENT, CARDIAC ARHYTHMIA</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Bernard A. Fitzgerald</u> MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9-5-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD | | | | 22e. ADDRESS 217 University Blvd E, Silver Spring MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/7/83 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD. | | 23e. DATE REC'D. BY REGISTRAR SEP 13 1983 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | 25b. REGISTRAR'S SIGNATURE <u>Se...</u> | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) George O Bynum | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/13/83 | | | 2b. HOUR 10:35 P.M. | |
| 3. SEX M | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR 05 10 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD | | | |
| 10. CITY OR TOWN OF DEATH Ft. Wash. Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ft. Wash. L. Rehabilitation Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Principal | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE California | | 13b. COUNTY San Diego | | 13c. CITY OR TOWN San Diego | | 13d. STREET ADDRESS 3733 Merrimac Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Bynum | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriett Free | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| 16b. SOCIAL SECURITY NO. 579-65-88320 | | 17. INFORMANT ADDRESS Mrs. Louise Butler-daughter-7504 Bellefield Avenue, Ft. Washington, Md. | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

1850

IMMEDIATE CAUSE (a) **METASTATIC CARCINOMA PROSTATE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 8-22 , 19 83 , to 9-13 , 19 83 , that (I) (we) lost saw the deceased alive on 9-13 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Wm. K. Forst | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. K. Forst M.D. | | | | 22e. ADDRESS 9401 Indian Head Hwy, Oxon Hill MD 20745 | | | |

| | | | |
|--|------------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Sept. 14, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Landerover, Maryland |
| 24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Road, SEP 23 1983 | | | |



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "M", "California", and "University" are faintly visible.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25057 REG. NO. | |
|--|--|-------------------------|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA MARY BYROM | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 9 21 19 83 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 18 1951 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 31 | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 21 19 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., DC | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook - Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Bladensburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4205- 55th Avenue 20710 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard H. Russ | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean Gannell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 579-70-9123 | | 17. INFORMANT ADDRESS Richard H. Russ (above address) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Closed head trauma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 9 P.M. 9-20-1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/auto collision. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Balto. Ave. & Edgewood St., College Pk. Prince George's, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon, M.D. | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 9-22-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/26/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Nalley's F. H. Inc. | | | | 24b. ADDRESS Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Gannell | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR P | |
| JACK | | Calloway | | | | | | 9 17 83 | | 3:27 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | Black | | Oct. 20, 1911 | | 71 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| N.Y. | | U.S.A. | | | | PRINCE GEORGE'S MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| CLINTON | | So. MD. Hosp CENTER | | | | | | Retired | | U.S. Gov't. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| D.C. | | N/A | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1727A F St., N.E. 99999 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Frank Calloway | | | | Lena Boyd | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | | | None | | Unknown | | 855 W 125th St. L.A., California | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Cerebral Vascular Accident | | | | | | | | | | | |
| 4360 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | STREET | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/26 19 83 to 9/17 19 83, that (I) (we) last saw the deceased alive on 9/17 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Stanley Josef | | | | | | | | 9-17-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Stanley Josef | | | | 7501 Surratts Rd Clinton, Md. 20735 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | |
| | | 9-24-83 | | HARMONY MEM. PARK | | | | CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | HIGHLAND PARK P.G. MD. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| H. S. WASHINGTON + SONS 4925 BURROUGHS AVE, N.E. | | | | | | | | SEP 28 1983 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE R. CAMPBELL | | | | 2b. HOUR 2:30AM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan 13 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 75 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Dist, Hgts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard B. Robertson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Louise Connick | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-38-8300 | |
| 17. INFORMANT 31 Boone Street | | 17. ADDRESS Cumberland, Md. 21502 | | 17. NAME William Robertson, Nephew | | 17. RELATIONSHIP | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Myocardial Aneurysm | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/11 8:30 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5711 SARVIS AVE Riverdale, MD | | 21g. DATE SIGNED 9/11/83 | | 21h. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22a. I certify that (a) (this hospital) attended the deceased from 9/11 8:30 1983 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE GABRIEL PARRIS | | 22c. ADDRESS 5711 SARVIS AVE Riverdale, MD | | 22d. DATE SIGNED 9/11/83 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-13-83 | | 23c. NAME OF CEMETERY OR CREMATORY Epiphany Ch. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Forestville, P.G. MD | |
| 24. FUNERAL DIRECTOR NAME Wilhelm Funeral Home Suitland, Md. | | 24. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Galt | |

BP

NOTES TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXPECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **NOT TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| FOR 1- STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 25060 REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF ESTI- DEATH MATED | | 3. SEX MALE | | 4. RACE WHITE | |
| WILLIAM S. CANE | | 9 22 83 19 | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1917 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR COUNTRY) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Capitol Heights | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 905 Larchmont Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roofer | | 12b. KIND OF BUSINESS OR INDUSTRY Roofing Co. | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Geo. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 905 Larchmont Avenue 20743 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Rumsey E. Cane | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 577 82 5104 | |
| 17. INFORMANT Dorothy M. Cane | | ADDRESS Same as #13 (Wife) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) Heart disease (c) Hypertension | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | |
| ACTUAL SIGNATURE SAID A. DAE | | TITLE (SPECIFY) M.D. Deputy | | MEDICAL EXAMINER | | DATE SIGNED 9-22-83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Said A. Dae, M.D. | | ADDRESS 5632 Annapolis Rd #10 Bladensburg, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/26/83 | | 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE SEP 28 1983 Inc. & Co. | |

SEP 28 1982

Willow

Nov. 10, 1917
Washington D.C.
State Department
Bureau of
Geography
and
Statistics
Washington D.C.

Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed extension of the boundary of the District of Columbia.

Very respectfully,
John M. Smith
Secretary



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE NEAREST DIVISION OF VITAL RECORDS. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VOLUNTARILY TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25061 REG. NO. | |
|---|-------------------------|---|---|---|---|--|--|---|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANDREA JACQUELINE CASEY | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9 22 19 83 | | 2b. HOUR M | | | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH Aug. 10, 1983 | 6. AGE (IN YEARS) LAST BIRTHDAY 1 12 YRS. | IF UNDER 1 YR. MONTHS 1 12 | IF UNDER 24 HRS. HOURS 1 12 MIN. | 2c. DATE PRONOUNCED DEAD 9 22 19 83 | | 2d. HOUR 8:19 AM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN Riverdale | | | |
| 14. FATHER'S NAME FIRST Ronnie MIDDLE Edwin LAST Casey | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Kathy MIDDLE Deshaum LAST Mobley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. None | | | 17. INFORMANT ADDRESS Kathy D. Casey Same as #13 (Mother) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 9-22-83 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (15) Burial | | | 23b. DATE 9/26/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Casch | | | |

STANDARD

July 10, 1917

Standard

Standard Engine Co.

Standard Engine Co.

Standard Engine Co.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathleen M. Gasey | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 24 83 | | | 2b. HOUR 9:05P M | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 29 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Md. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | 13c. COUNTY Prince George | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6809 Geneva Lane | | 20748 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Moran | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Morgan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 212-40-3480 | | 17. INFORMANT ADDRESS Michael J. Casey, Sr. Temple Hills, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 5750 DUE TO, OR AS A CONSEQUENCE OF, (b) ABSCESS OF GALLBLADDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF, (c) severe cholangitis | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hepatorenal syndrome | | | | | | | | | |
| 19a. DATE OF OPERATION 9/9/83 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GALLBLADDER ABSCESS | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/24 83 to Sept 29 1983 , that (I) (we) last saw the deceased alive on 9/24 1983 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | DEGREE | | 22c. DATE SIGNED 9/25/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank M. Ryan M.D. | | | | | 22e. ADDRESS 9801 Indian Hill High FF WASH Md 20744 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/27/83 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland | | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home | | | | | 24b. ADDRESS Oxon Hill, Md. | | 24c. DATE REC'D. BY REGISTRAR SEP 28 1983 | | 24d. REGISTRAR'S SIGNATURE [Signature] |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GERTRUDE E. CHARLES | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/20/83 | | | | |
| 3. SEX F | | | | | 2b. HOUR 5 a.m. | | | | |
| 4. RACE W | | | | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1902 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. | | | | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS. | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | |
| 10. CITY OR TOWN OF DEATH Adelphi | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. Md. | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Paint Branch Nursing Home | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Supervisor | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY C. & P. Tel. Co. | | | | | | | | | |
| 13a. STATE Md. | | | | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13c. COUNTY Pr. Geo. | | | | | 13d. STREET ADDRESS 7611 - 25th Avenue | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anthony Schneider | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Kendrick | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 577-01-0951 | | | | |
| 17. INFORMANT ADDRESS Same as | | | | | 18. NAME OF INFORMANT Regina C. Price (Daughter) above | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CEREBRAL ATROPHY 2° TO CEREBRAL VASC. INSUFF. DECUBITUS | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/19/83 to 9/20/83 , that (we) lost the deceased above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Harold W. Draper M.D. | | | | | 22c. DATE SIGNED 9/20/83 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD W. DRAPER M.D. | | | | | 22e. ADDRESS 9801 GEORGIA AVE, SILVER SPRING, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 9-22-83 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1983 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | |

BP _____

Handwritten notes and stamps, including a large circular stamp in the center and various illegible markings.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|-------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Sentell | | 2a. DATE OF DEATH MONTH DAY YEAR 9-20-83 | | 2b. HOUR 0710 M | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 5 29 99 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | 9. BALTIMORE CITY OR COUNTY OF DEATH (Prince Georges Co) Clinton, MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Maryland Hospital Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | |
| 13a. STATE Md. | | 13b. COUNTY Pr. Geo. C. | | 13c. CITY OR TOWN Clinton | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Henry Cheffens | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Earls | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 425 12 1053 | | 17. INFORMANT Mrs. Iola Horton | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Pulmonary - pneumonia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 9/20 , 19 83 , that (I) (we) last saw the deceased alive on 9/19 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE R. N. Horton | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/21/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. N. Horton | | 22e. ADDRESS 4235 25th Ave Md 21246 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept/27/83 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG County Md. | | 23e. DATE REC'D. BY REGISTRAR SEP 29 1983 | | | |
| 24. FUNERAL DIRECTOR NAME R. N. Horton Co. Mort. Inc. | | ADDRESS 600 Kennedy St NW | | 25a. REGISTRAR'S SIGNATURE John J. Conner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|--|----------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET C. CHESTNUTIS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT 21 1983 | | 2b. HOUR 9 40 PM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 14 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Laurel | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 12204 Cedarbrook Lane 20708 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No Yes | | | | 16b. SOCIAL SECURITY NO. 022-12-5934 | | 17. INFORMANT ADDRESS | | | |
| 16c. WW II, Navy | | | | 046-22-4250 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Advanced metastatic carcinoma breast 5 YRS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-11-83 to 9-21-83 , that (I) (we) lost saw the deceased alive on 9-21-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE M. Baig, M.D. | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/22/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. BAIG, M.D. | | | | 22e. ADDRESS 3754 FORT MEADE RD, LAUREL, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 9/22/83 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | |

BP

MARGARET C. CHRISTIAN

SENT 21 1987 1 10 PM

Female

IN 23

ED

PRINCE GEORGES COUNTY

PRINCE GEORGES GENERAL HOSPITAL

CHIEF

10304 Charlottetown, P.E.I.

10304

MR.

NO 10304-25-1550

9/11/83

10304

10304

9/29/83 August P. Rodriguez
Corrected death certificate

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

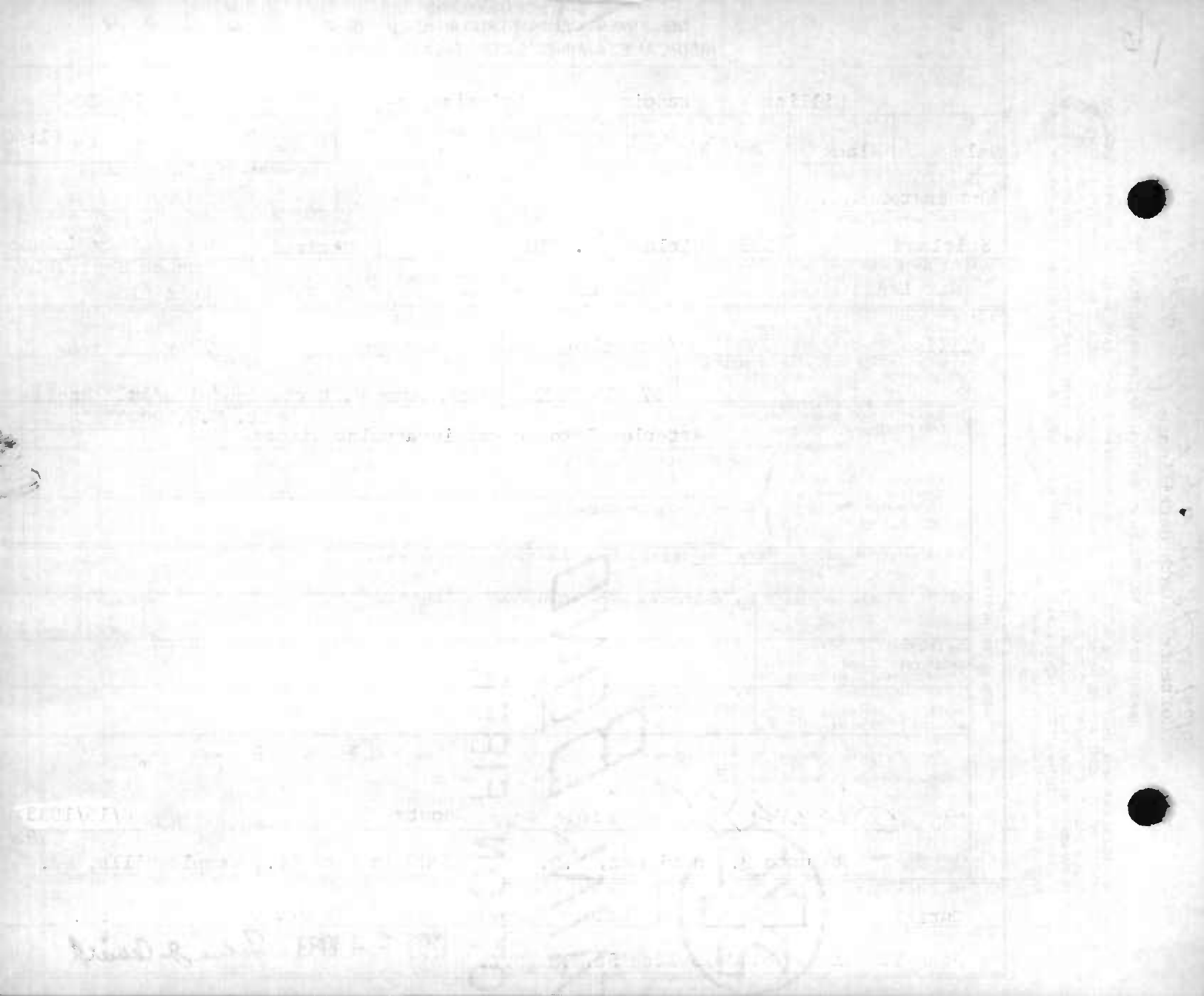
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25066 | |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) William Francis Christian, Jr. | | | | | | | 2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input checked="" type="checkbox"/> 8 14 1983 | | 2b. HOUR <input type="checkbox"/> M | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH Nov DAY 24 YEAR 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | | 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | 7c. DATE PRONOUNCED DEAD MONTH 8 DAY 16 YEAR 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH P.B. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Suitland | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3958 Suitland Rd. #104 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY City Maintenance Dept., L.A. | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Suitland | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3958 Suitland Road #104 | | | |
| 14. FATHER'S NAME FIRST William MIDDLE F. LAST Christian, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST Madelyn MIDDLE Abby LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 578-18-2482 | | 17. INFORMANT ADDRESS Mrs. Mary V. Christian/wife/1021 Euclid St. N.W. 20007 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy M.D. | | | | DATE SIGNED 9/29/1983 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 8-19-83 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION CITY OR TOWN Landover, COUNTY Md. STATE | | | |
| 24. FUNERAL DIRECTOR NAME John T. Rhines Co., ADDRESS 3015 12th St. N.E., D.C. 20017 | | | | | | | | | | | |

RECORDED BY REGISTRAR
4 1983

REGISTRAR'S SIGNATURE
John J. Ganiel



40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

DHMH - 16 50M 4/82
(VRA 15. 4)

| | | | | | |
|---|--|---|---|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| JENNIE | | 9-24-83 | | 7:25 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. YRS. |
| Female | White | 6 5 08 | 75 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A | | Prince Georges | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CLINTON MD | SOUTHERN MD. HOSP | TEACHER | Public Sch | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MD | P.G. | ACCOKEEK | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 14301 JOHN CLAGETT DR | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | | | |
| Peter | Maria | 213-38-1622 | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 17b. SOCIAL SECURITY NO. | 17c. INFORMANT | 17d. ADDRESS | | |
| NO | 213-38-1622 | John H. Clagett, Jr. | same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Bilateral pneumonia and</u> | | | | | 12 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hemorrhagic gastro</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>perforated ulcer</u> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 9-3-83 | Perforated ulcer | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | 9 P.M. | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | CITY OR TOWN | COUNTY | STATE |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-6</u> 19 <u>83</u> to <u>9-24</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/24</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | |
| JOHN F. WOLSKI | | | 9-25-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | 22f. DATE REC'D. BY REGISTRAR | | | |
| JOHN F. WOLSKI, MD | 2015 WOODYARD Rd. CLINTON MD 20735 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 9-28-83 | Christ Epis. Cem. | ACCOKEEK, P.G. Maryland | | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Huntt Funeral Home, Waldorf, Maryland | SEP 27 1983 | | J. J. J. | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25068

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|--|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL G CLEMENTS | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 29 83 11:35A.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 22, 1896 | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY -- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. CITY OR TOWN PG | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 1017 Iago Avenue 20743 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hugh Lewis Shires | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Allie May Makowicz | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 577-84-0694 | 17. INFORMANT ADDRESS Gertrude Carruth Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Complete Heart Block</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Coronary Heart Failure, D.M. HBP</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-25</u> , 19 <u>83</u> , to <u>9-29</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9-29</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <u>Abul Hasan U Ansari</u> MD | | 22c. DATE SIGNED 9-29-83 | | 22d. ADDRESS 10905 FORT WASH. RD #207 FT. WASH. Md. 20744 |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) ABULHASAN U ANSARI | | 22f. ADDRESS 10905 FORT WASH. RD #207 FT. WASH. Md. 20744 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 10-3-83 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home | | DATE RECD. BY REGISTRAR 25th REGISTRAR'S SIGNATURE OCT 4 1983 John J. Canfield | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes in the upper section of the page, appearing as several lines of cursive script.

Handwritten notes in the middle section of the page, continuing the cursive script.

Handwritten notes in the lower section of the page, including a signature or date at the bottom.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3, 4, AND 5 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

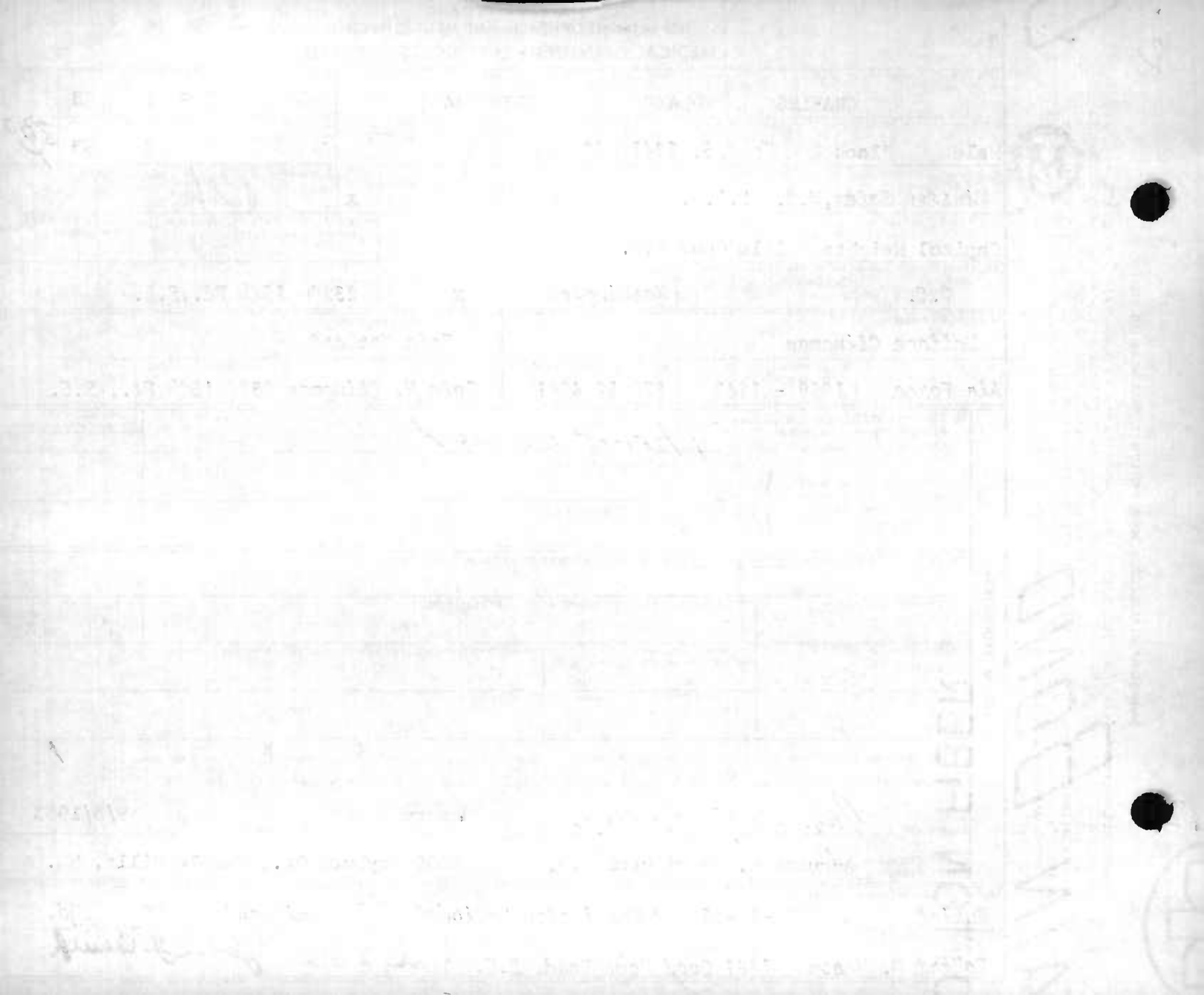
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25069

REG. NO.

| | | | | | | | | |
|---|-------------------------|---|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES ROLAND CLINGMAN | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9 8 1983 | | | 2b. HOUR M | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR June, 5, 1941 | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 9 8 1983 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Winsten Salam, N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PA. | | |
| 10. CITY OR TOWN OF DEATH Capitol Heights | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1416 Opus Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE D.C. | | | 13b. COUNTY | | 13c. CITY OR TOWN Washington | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS 2320 15th Pl., S.E. | | | 13f. CITY OR TOWN 99999 | | | 13g. STATE PA. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wallace Clingman | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iola Herbert | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Air Force | | 16b. SOCIAL SECURITY NO. 579 52 6901 | | 17. INFORMANT ADDRESS Iola H. Clingman 2320 15th Pl., S.E. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Throat Cancer 1490 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez, M.D. | | TITLE (SPECIFY) Deputy | | | MEDICAL EXAMINER | | DATE SIGNED 9/8/1983 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 09-12-83 | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Robert G. Mason 1661 Good Hope Road, S.E. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Chief | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GRADY Tillman COCKCROFT | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 19 83 | | | 2b. HOUR 7:25 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 9 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi | | 7b. CITIZEN OF WHAT COUNTRY? U. S. of A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman Ord. | | 12b. KIND OF BUSINESS OR INDUSTRY N.O.S.-Ret. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. CITY OR TOWN Charles Bryans Rd. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS P. O. Box 302 Zip: 20616 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leaseon Cockcroft | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Breland | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1928-1934 | | 17. INFORMANT Hilda V. Cockcroft | | ADDRESS Same as No. 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cordiac Arrest DUE TO, OR AS A CONSEQUENCE OF Acute Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/19 83 to 9/19 83 , that (I) (we) lost saw the deceased alive on 9/19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R. McConaughy | | | | | | DEGREE MD | | 22c. DATE SIGNED 9/19/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. McConaughy, M.D. | | | | | | 22e. ADDRESS 5620 St. Barnabas Rd., Marlow Heights, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 09/21/83 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md. | | |
| 24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

Name: Wanda
 Sex: Female
 Race: White
 Date of Birth: 1925
 U.S. of A. Mississippi
 Social Security No. 000-000-000
 Maryland Driver License No. 123456789
 Last Name Wanda
 First Name Wanda
 Middle Name Wanda
 Date of Birth 1925
 U.S. of A. Mississippi
 Social Security No. 000-000-000
 Maryland Driver License No. 123456789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY Marcella COLLINS | | | 2a. DATE OF DEATH | | MONTH DAY YEAR 9 / 20 / 83 | |
| 3 SEX Female | | | 4 RACE Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR December 10, 1903 | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 79 | | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas | | 7b. CITIZEN OF WHAT COUNTRY? United States | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County | | MD. | |
| 10 CITY OR TOWN OF DEATH Cheverly | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY Home | | | 13a. STREET ADDRESS 1138-2 Columbus Circle 20748 | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Frank Gabriel | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecelia Storm | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | |
| 16b. SOCIAL SECURITY NO. 115-28-9050 | | | 17 INFORMANT Paul Fallon, | | ADDRESS Same as 13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) infection, probably pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Breast cancer with metastases and CVA | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/23, 1983 , to 9/20, 1983 , that (I) (we) last saw the deceased alive on 9/20, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Robert J. Ginsberg MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED September 20, 1983 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. GINSBERG | | 22e. ADDRESS 6501 Landover Rd. Cheverly MD 20785 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE September 24, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Auburn, New York |
| 24 FUNERAL DIRECTOR NAME Farrell's Funeral Home | | 24b. ADDRESS 82-84 South Street, Auburn, NY 13021 | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Canine |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

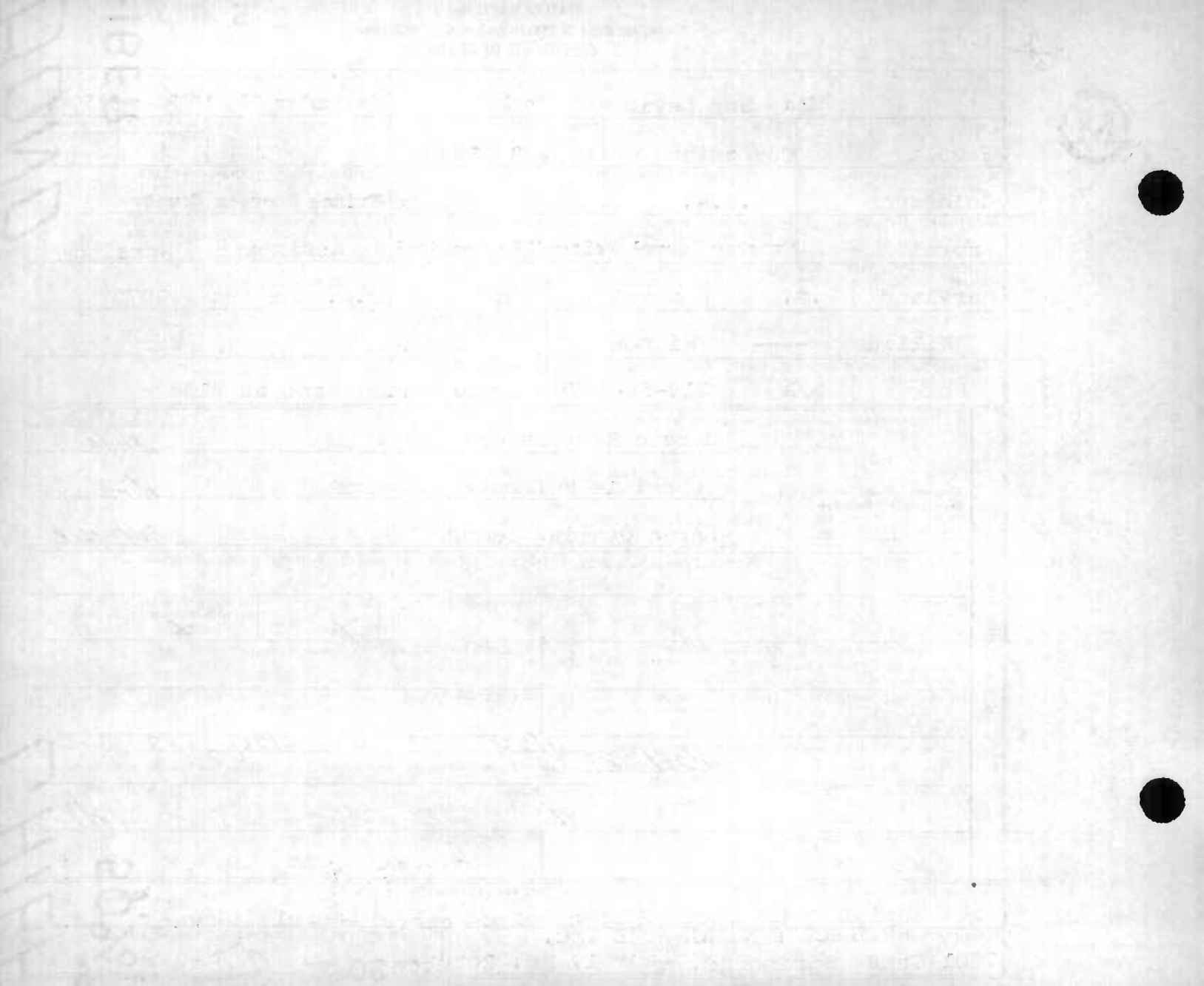
| | | | | |
|---|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Rita Sue Lewis Cook | | 2a. DATE OF DEATH MONTH DAY YEAR September 26, 1983 | | 2b. HOUR 3:56 A.M. |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 3 1949 | | 6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. |
| 10. CITY OR TOWN OF DEATH Laurel | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assistant | 12b. KIND OF BUSINESS OR INDUSTRY Nursing |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. CITY OR TOWN P.G. | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE P.O. Box 694 20707 |
| 14. FATHER'S NAME FIRST MIDDLE LAST William ---- Wilson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Wright | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES AND OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | 17. INFORMANT ADDRESS Minnie Lewis Same as #13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 2395 DUE TO, OR AS A CONSEQUENCE OF (b) Possible Pulmonary Embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Large Ovarian Tumor | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Mins. Mins. ONE YEAR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/24/83 to 9/26/83 , that (I) (we) lost saw the deceased alive on 9/25/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE R. MAGGIO | DEGREE MD | | 22c. DATE SIGNED 9/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. MAGGIO, MD | | 22e. ADDRESS LAUREL, MD 20708 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 28 Sept 83 | 23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Howard Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS FLECK FUNERAL HOME INC. 7601 Sandy Spring Rd. Laurel, Md. 20707 | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1983 | | |
| | | 25b. REGISTRAR'S SIGNATURE John J. Canale | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 2)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL/WORK ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | 2b. HOUR | | | |
| Mary Ann Corcoran | | | | Sept. 12, 1983 10:45 PM | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | Dec. 3, 1888 | | 94 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| Washington, D.C. | | U.S.A. | | | | Prince Georges MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hyattsville | | Carroll Manor | | Homemaker | | Residence | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | |
| 13a. STATE 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| none none | | | | Wash., D.C. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| William P. Corcoran | | | | Mary Ellen Twomey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | |
| no | | | | 579-60-2610 | | | |
| 17 INFORMANT | | | | ADDRESS | | | |
| Helen Gormley | | | | Wash. D.C. 4820 45 Street N.W. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 2765 IMMEDIATE CAUSE (a) Cachexia - Dehydration | | | | | | | 2 weeks |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| Chronic Brain Syndrome due to Cerebral Arteriosclerosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19 83 to Sept. 12, 19 83, that (I) (we) lost saw the deceased alive on July 2, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| J. Neill Kennedy, M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | Sept. 13, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| J. Neill Kennedy, M.D. | | | | 1145 19 st. N.W. Washington, D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | Sept. 16, 83 | | Mt. Olivet Cemetery | | Washington, D.C. | |
| 24 FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| DeVol Funeral Home | | | | SEP 19 1983 | | | |



Washington, D.C. 20540
Mr. J. Edgar Hoover
Director
Federal Bureau of Investigation
U.S. Department of Justice
Washington, D.C. 20535
Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.
Very truly yours,
[Signature]
Special Agent in Charge

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.
Very truly yours,
[Signature]
Special Agent in Charge
Washington, D.C. 20535
J. Edgar Hoover
Director
Federal Bureau of Investigation
U.S. Department of Justice
Washington, D.C. 20535

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | September 18, 1983 | | | 3:00A M | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE | | |
| Female | | | White | | | Nov. 29 1898 | | | 84 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Texas | | | U.S.A. | | | | | | Prince George's MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Laurel | | | Greater Laurel Beltsville Hospital | | | Homemaker | | | Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? | | | 14. STREET ADDRESS | | |
| D.C. 20015 | | | Washington | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 5420 Conn. Ave., N.W. 99999 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Francis S Ainsa | | | Roselle McNamee | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | 578-50-9475 | | | Ann C Harris | | | 9004 Briardale Ln., Laurel, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) 4100 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOPULMONARY ARREST | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) MYOCARDIAL INFARCTION | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | STREET | | | CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) this hospital attended the deceased from 9/17/83, to 9/18/83, that (1) we last saw the deceased alive on 9/17/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (2) we (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | | | | |
| Gregory A. Compton MD | | | | | | 9-18-83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | |
| Gregory A. Compton MD | | | 4201 LAUREL PARK DR #104 | | | LAUREL MD 20707 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| Burial | | | 9/21/1983 | | | Arlington National Cem. | | | Arlington Virginia STATE | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C. | | | | | | | | | | | |
| DATE REC'D. BY REGISTRAR 03 1983 REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one of the following:

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|-----------------|--|-------|--|--------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 7a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 7b. HOUR | |
| THELMA | | L | | COWARD | | | | 09 | | 04 | | 83 | | 10:45A | | | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| FEMALE | | BLACK | | APRIL 1 1914 | | 69 | | YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| VIRGINIA | | U.S.A. | | | | PRINCE GEORGE'S COUNTY | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| CHEVERLY | | PRINCE GEORGE'S GENERAL HOSP. | | CLERK | | US GOVERNMENT | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MARYLAND | | PR. GEO. 'S SEAT PLEASANT | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7244 G STREET | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| MOSES BUSHROD | | ELAINE McCLAIN | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 577 01 5665 | | ALEXANDER COWARD SEAT PLEASANT, MD. | | 7244 G STREET | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Cerebrovascular Accident | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 4100 | | DUE TO, OR AS A CONSEQUENCE OF | | (b) Acute Myocardial Infarction | | 34 days | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | Diabetes Mellitus | | Gangrene | | Chond | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 9/2/83 | | Amputation of right wrist and forearm | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 3</u> 19 <u>83</u> to <u>Sept 9</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Sept 3</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | | | |
| Norman Lieberman | | | | 9/4/83 | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| NORMAN LIEBERMAN, MD. | | 5100 4th WAY | | Suitland md | | 20746 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| BURIAL | | 9/8/83 | | LINCOLN MEMORIAL | | SUITLAND, MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| ROLLINS FUNERAL HOME, INC. | | 4339 HUNT PLACE, N.E. | | SEP 13 1983 | | John J. Connel | | | | | | | | | | | |

Q. M. 11111111

BP

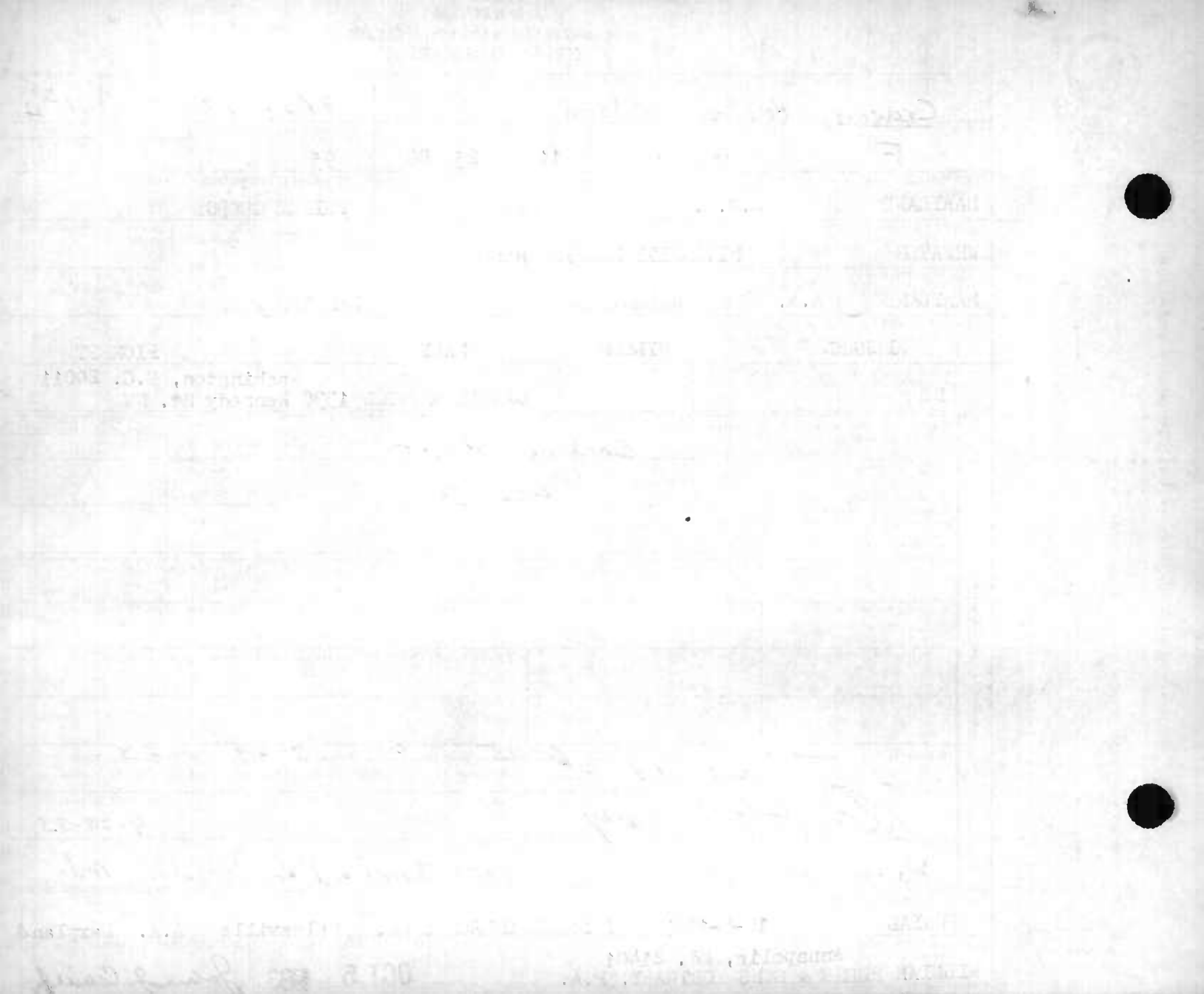
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR - STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>Crowner, Rachel Wilson</u> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>9/29/83</u> | | | | |
| 3. SEX <u>F</u> | | 4. RACE <u>B</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>11 25 88</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>95</u> YRS. | | 7b. HOUR <u>10:5 AM</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>PRINCE GEORGE</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH <u>WHEATON</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>UNIVERSITY NURSING HOME</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <u>MARYLAND</u> | | 13b. COUNTY <u>A.A.</u> | | 13c. CITY OR TOWN <u>GALESVILLE</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>BENNING ROAD 20765</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>RICHARD WILSON</u> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MARY PICKETT</u> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Washington, D.C. 20011</u> <u>CALVIN SNOWDEN 1330 Kennedy St. NW</u> | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: <u>4292 Cardiac Arrest</u> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>6-15</u> , 19 <u>81</u> to <u>9-29</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>Sept 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (we) (we) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Walter Goozh</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>9-29-83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Walter Goozh</u> | | | | 22e. ADDRESS <u>2309 Shorefield Rd. Wheaton, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>10-4-1983</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER CHURCH CEME.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Galesville A.A. Maryland</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>WILLIAM REESE & SONS MORTUARY, P.A.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>OCT 5 1983</u> | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conish</u> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25071

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|-----------------|--|--|--|--|--|----------------------|--------------------------|--|---|--|----------------|--|---|--|----------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MABEL | | | FIRST S. | | | MIDDLE S. | | | LAST Cullinan | | | 2a. DATE KNOWN OF DEATH | | MONTH 9 | | DAY 23 | | YEAR 83 | | 2b. HOUR 3.25 | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH JULY DAY 20 YEAR 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | IF UNDER 1 YR. MONTHS XX DAYS XX HOURS XX MIN. XX | | 7c. DATE PRONOUNCED DEAD | | MONTH 9 | | DAY 23 | | YEAR 83 | | 2d. HOUR 3.23 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LELAND MEMORIAL | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE MD | | | | 13b. COUNTY P.G. | | | | 13c. CITY OR TOWN UNIVERSITY PARK | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 4402 Beechwood Rd | | | |
| 14. FATHER'S NAME FIRST HENRY MIDDLE SCHRASS LAST CHRISTINE | | | | 15. MOTHER'S MAIDEN NAME FIRST JORDAN MIDDLE 20782 LAST 20782 | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO NO | | | | 16b. SOCIAL SECURITY NO. 220-58-7493 | | | | 17. INFORMANT FRANK P. CULLINAN ADDRESS SAME AS 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE SAID A. DAKEN | | | | TITLE (SPECIFY) M.D. Demitri | | | | MEDICAL EXAMINER | | | | DATE SIGNED 9-24-83 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis Rd | | | | ADDRESS Bladenburg MD 20710 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 9-26-83 | | | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY | | | | 23d. LOCATION CITY OR TOWN SILVER SPRING COUNTY MONT. STATE MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | | ADDRESS 500 UNIVERSITY BLVD. WEST, SILVER SPRING, MD 20901 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1983 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | |

CHRISTIAN

22-02-1962



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| FOR 1. STATE REGISTRAR | | | | | REG. NO. 25078 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NINA LESBY CUMMINS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 12 83 | | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 3 20 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 90 YRS. | | 2b. HOUR 250 PM | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH MD PG MD | | | |
| 10. CITY OR TOWN OF DEATH LAUREL | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL NSG HOME, LAUREL 14200 PARK DRIVE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 13a. STATE MARYLAND | | 13b. COUNTY ANNE ARUNDEL | | 13c. CITY OR TOWN LAUREL | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3563 FT. MEADE RD. 20707 | |
| 14. FATHER'S NAME (TYPE OR PRINT) MANOAH MCINTURFF | | | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) AMANDA SEBINA CLEM | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 578-50-6215 | | 17. INFORMANT ADDRESS NINA L. GROVE 3563 FT. MEADE RD., LAUREL | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4539 IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sent to hospital thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 d 17 mt | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Atrial fibrillation</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21/80, 19____, to 9/12/83, 19____, that (I) (we) lost saw the deceased alive on 9/12/83, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Robert S. McConay M.D.</u> | | | | DEGREE | | 22c. DATE SIGNED 9/12/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. McConay M.D. | | | | 22e. ADDRESS 402 Main St. Laurel, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/14/83 | | 23c. NAME OF CEMETERY OR CREMATORY CHESTNUT GROVE CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE HERNDON FAIRFAX VA | | | |
| 24. FUNERAL DIRECTOR NAME J. BERKLEY GREEN | | | | ADDRESS 721 ELDEN ST., HERNDON, VA | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u> | |

BP



10%

COIL



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) PAULINE Mary CUNHA | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 30, 1983 | | 2b. HOUR 10:15a _M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1981 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Washington DC | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH LANHAM | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL OF P.G. CO. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Accounting | | 12b. KIND OF BUSINESS OR INDUSTRY USGovt |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Maryland | 13b. COUNTY PG | 13c. CITY OR TOWN Forestville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2716 Boones Lane 20747 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John F. Johnson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lela Crismond | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -- | | 16b. SOCIAL SECURITY NO. 219-30-8582 | | 17. INFORMANT ADDRESS Lewis M. Hayden 2012 Brewton St Dist. Hts. Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) / DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-26-83 to 9-30-83, that (I) (we) lost saw the deceased alive on 9-29-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE MHA al MD. | | DEGREE MD. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUSHTAQ A. SHAH | | 22e. ADDRESS 4637 Eastern Avenue, Mt. Rainier, Md. 20712 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-4-83 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton PG Md |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home | | 25. DATE READ BY REGISTRAR OCT 6 1983 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

28%
C-100



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOVIE MYRTLE CUPP | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 10, 1983 | | 2b. HOUR 10:24^{AM} |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR March 17, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Langham | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Des Hospital Langham | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Textile Worker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY PG | 13c. CITY OR TOWN Langham | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 9312 Fontana Dr 20706 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas W. Cupp | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn (NA) Green | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 238-07-2634 | | 17. INFORMANT ADDRESS Jana Webster (Same as #13A) | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4120

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Malnutrition**

DUE TO, OR AS A CONSEQUENCE OF

(c) **old antero-septal myocardial infarction**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

| | | | |
|--|--|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 30 , 19 83 , to 9/10 , 19 83 , that (I) (we) lost saw the deceased alive on 9/10 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Thomas Y. Ko | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED Sept 10 '83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | |
|---|--------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 13 Sept 83 | 23c. NAME OF CEMETERY OR CREMATORY Torrest Lawn Center | 23d. LOCATION CITY OR TOWN COUNTY STATE Charlotte Mecklenburg, NC |
| 24. FUNERAL DIRECTOR NAME ADDRESS Rakes Langham Fk 9013 Langham Rd Langham | | 25a. DATE REC'D BY REGISTRAR (BY REGISTRAR'S SIGNATURE) SEP 21 1983 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MARGARET STELLA CURTIN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT - 8 - 1983 2b. HOUR 1:38 M | | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR OCT. 3, 1911 | | 6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | |
| 10. CITY OR TOWN OF DEATH CLINTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STREET ADDRESS 20772 | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY PR. GEO'S | | 13c. CITY OR TOWN UPPER MARLBORO | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4505 RITCHIE-MARLBORO RD | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JAMES ALFRED BRYAN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY GERTRUDE CURTIN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. --- | | 17. INFORMANT ADDRESS 4505 RITCHIE-MARLBORO RD., UPPER MARLBORO, MD. 20785 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST- 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK. 24 HRS. (c) ACUTE MYOCARDIAL INFARCTION 72 HRS. | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (SEE ITEM 21b) (MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY, INTERNAL OR EXTERNAL, OR PART 2) | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 001 19 69 to PRESENT , that (I) was last saw the deceased alive on SEPT 7 19 83 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) have (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Arthur Shaver Jr MD DEGREE MD | | | | | 22c. DATE SIGNED 9/8/83 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR SHAVER JR | |
| 22e. ADDRESS 9131 PISCATAWAY RD CLINTON MD, 20735 | | | | | 22f. ADDRESS 9131 PISCATAWAY RD CLINTON MD, 20735 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | 23b. DATE 9/12/83 | | 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE CLINTON (Pr. Geo's) MD. | | |
| 24. FUNERAL DIRECTOR RICHARD A. COLEMAN-UPPER MARLBORO, MARYLAND 20772 | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1983 | | 25b. REGISTRAR'S SIGNATURE James J. Smith | | |

BP

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RECEIVED
OCT. 3, 1911

CLINTON
JAMES
VICTOR E. GORDON
27732

ROUTE 1
CLINTON

CLINTON
JAMES
VICTOR E. GORDON
27732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25082

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Ignatius Curtis | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 13 1983 | | 2b. HOUR 1:38 PM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 11 - 1 - 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD | | |
| 10. CITY OR TOWN OF DEATH CLINTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | 12b. KIND OF BUSINESS OR INDUSTRY Labor | |
| 13a. STATE Md | | 13b. COUNTY P.G. | 13c. CITY OR TOWN Brandywine | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS Rt 3 Box 286 20613 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard Curtis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Nesl | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 597-50-9749 | | 17. INFORMANT Sarah Curtis SAA | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerotic Vasc. Disease</u> Yrs | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 6 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CVA, Diabetes</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>June 1</u> 19 <u>71</u> , to <u>Sept 13</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Sept 13</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Thomas L. Feldson MD | | | | 22c. DATE SIGNED 9/13/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. FIELDSON, M.D. | | | | 22e. ADDRESS BRANDYWINE, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | 23b. DATE 9-17-83 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md | |
| 24. FUNERAL DIRECTOR NAME Montel Adams | | ADDRESS Ciguera Md 20607 | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | 25b. REGISTRAR'S SIGNATURE R. E. Brind |

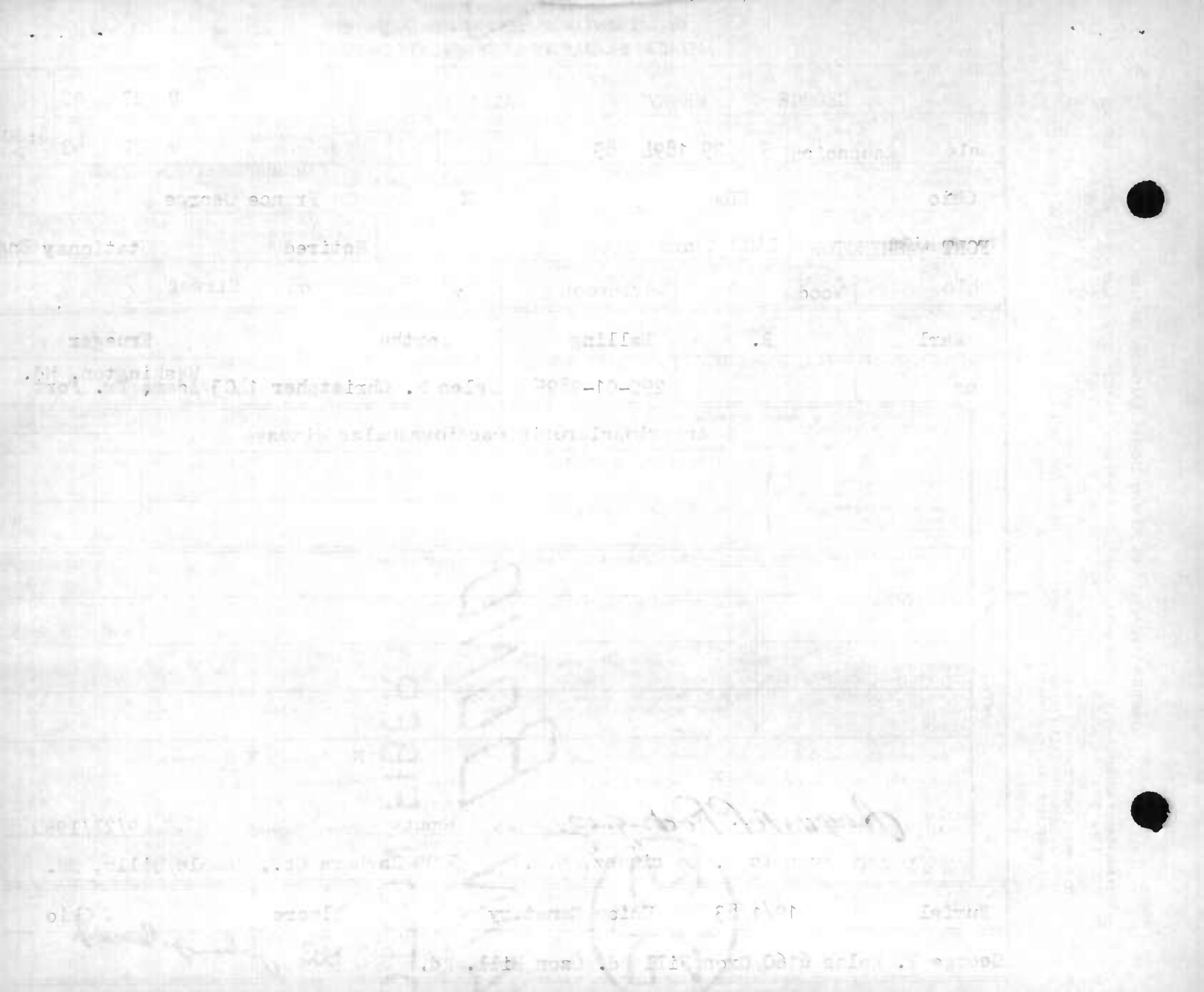
MEDICAL CERTIFICATION

CHIEF

12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25083 | |
|---|--|--------------------------|---|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE HENRY DALLING | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 9 27 19 83 | | 2b. HOUR 8:30 P.M. | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH 5 DAY 29 YEAR 1894 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 89 YRS. | | 7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD MONTH 9 DAY 27 YEAR 19 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | |
| 10. CITY OR TOWN OF DEATH FORT WASHINGTON | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1403 Adams Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY Stationary Eng | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Ohio | | 13b. COUNTY Wood | | 13c. CITY OR TOWN Northwood | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 14. STREET ADDRESS 200 Road Street 99999 | | | |
| 14. FATHER'S NAME FIRST Karl MIDDLE R. LAST Dalling | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE Krueger LAST Krueger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 290-01-9895 | | 17. INFORMANT ADDRESS Helen M. Christopher 1403 Adams Dr. Fort Washington, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez M.D. | | | | | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | DATE SIGNED 9/27/1983 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10/1/83 | | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | | | 23d. LOCATION CITY OR TOWN Elmore COUNTY Ohio STATE Ohio | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas ADDRESS 5160 Oxon Hill Rd. Oxon Hill, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 03 1983 REGISTRAR'S SIGNATURE John Smith | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25084

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|-----------------------------------|--|--|--|--|--|------------|--|--|-------------------|--|--|------------|--|--|------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Arthur | | | MIDDLE C | | | LAST Davis | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | MONTH 9 | | | DAY 24 | | | YEAR 83 | | | 2b. HOUR 8:29 | | | | | | | | | | | | | | |
| 3. SEX M | | | 4. RACE Black | | | 5. DATE OF BIRTH MONTH July | | | DAY 10 | | | YEAR 1894 | | | 6. AGE (IN YEARS) LAST BIRTHDAY 89 YRS. | | | IF UNDER 1 YR. MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | 7c. DATE PRONOUNCED DEAD | | | MONTH 9 | | | DAY 24 | | | YEAR 83 | | | 2d. HOUR 8:04 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | | 8. MARRIED WIDOWED <input checked="" type="checkbox"/> | | | NEVER MARRIED <input type="checkbox"/> | | | DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Landover | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2715 Hawthorne Terr. | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Univ. of Md. | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY P.G. | | | 13c. CITY OR TOWN Landover | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 2715 Hawthorne Terrace | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Sidney | | | | | | MIDDLE Davis | | | | | | LAST Davis | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary | | | | | | MIDDLE Jane | | | | | | LAST (Unknown) | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | (IF YES, GIVE WAR OR DATES) | | | | | | 16b. SOCIAL SECURITY NO. 577-30-7348 | | | | | | 17. INFORMANT Theodore Mason-5600 R.I. Ave. Hyattsville, Md. | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE SAID A. DARR M | | | | | | TITLE (SPECIFY) M.D. Deputy | | | | | | MEDICAL EXAMINER | | | | | | DATE SIGNED 9-24-83 | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis Rd | | | | | | ADDRESS Bladensburg MD 20710 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | 23b. DATE 9/30/83 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park | | | | | | 23d. LOCATION CITY OR TOWN Highland Park, Md. COUNTY STATE | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME H.S. WASHINGTON + SONS | | | | | | ADDRESS 4925 BURROUGHS AVE. N.E. | | | | | | 25. DATE REC'D. BY REGISTRAR OCT 03 1983 | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | | | | | | | | | | | | |

18

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 25085

FOR
1. STATE
REGISTRAR

| | | | | |
|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Ethel S. Dennison | | 2a. DATE OF DEATH MONTH DAY YEAR September 21, 1983 | | 2b. HOUR P. 2:45 M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR May 13, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. |
| 10. CITY OR TOWN OF DEATH Forestville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BookBinder | 12b. KIND OF BUSINESS OR INDUSTRY GPO |
| 13a. STATE Maryland | 13b. COUNTY PG | 13c. CITY OR TOWN N. Forestville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2719 Overdale Place |
| 14. FATHER'S NAME FIRST MIDDLE LAST Perry Skinner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Hurst | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -- | | 16b. SOCIAL SECURITY NO. 235-12-6285 | | 17. INFORMANT Helen Peterson |
| | | | | ADDRESS Same as #13 |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia

4360

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) CVA

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-18</u> , 19 <u>81</u> , to <u>9-21</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9-17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>William Kent Furst</u> | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 9/21/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Kent Furst | | 22e. ADDRESS 9401 Indian Head Hwy, Ft. Washington Md | |

| | | | |
|---|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9-24-83 | 23c. NAME OF CEMETERY OR CREMATORY Marshville Baptist Church Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Marshville W. Va. |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home | | ADDRESS Suitland, Md | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 |
| | | 25b. REGISTRAR'S SIGNATURE <u>R. E. Wilhelm</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001-103-802

001-103-802

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, ADVISE THE JURY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PARAGRAPHS 1, 2, AND 3 TO THE CORONER'S DIRECTOR.
PARAGRAPH 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 OF YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DHMH - 17
(VR A15 ME (5))
20M 4/B2

| | | | | | | | | | |
|--|------------------|---|--|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 25086 | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Beatrice A. Dixon | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 9/19 1983 | | 2b. HOUR 12pm | |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH 1 DAY 20 YEAR 1902 | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 9/19 19 | | 2d. HOUR 12:40 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater-Laurel Beltsville Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Md | | 13b. COUNTY AA | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 239 Red Clay Road 20707 | |
| 14. FATHER'S NAME FIRST Coley Williams MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST Hardenia Nelson MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. 579-01-2765 D | | 17. INFORMANT Laurel, Maryland 20707 Ernest D. Dixon, son, 239 Red Clay Rd., #202 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE Said A. Daee | | | | TITLE (SPECIFY) Deputy M.D. | | MEDICAL EXAMINER | | DATE SIGNED 9/20/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Said A. Daee, M.D. | | | | ADDRESS 5632 Annapolis Rd. #10 Bladensburg Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 22, 83 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Highland Park, P.G., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME McGuire Funeral Home | | ADDRESS 7400 Georgia Ave. NW Washington, D.C. 20012 | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT



10-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25087 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Barbara Jean DOCEKAL | | | | 2b. HOUR 8:50 PM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 29 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 51 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD | |
| 10. CITY OR TOWN OF DEATH LANHAM | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 13a. STATE Maryland | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edwin F. Connolly | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Carney | | 13e. STREET ADDRESS 2904 Jamestown Road | | Zip 20782 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 337-24-4666 | | 17. INFORMANT ADDRESS Edward G. Docekal Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure 5715 DUE TO, OR AS A CONSEQUENCE OF: (b) Cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Shock Lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months years 3-5 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/17 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/21 1983 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-21 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Nathan Sherman | | DEGREE M.D. | | 22c. DATE SIGNED 9/23/83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATHAN SHERMAN, M.D. | |
| 22e. ADDRESS 8118 Goodluck Rd., Lanham, Md. 20706 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9-26-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md. | |
| 24. FUNERAL DIRECTOR NAME Francis Gasch's Sons | | ADDRESS Hyattsville, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY H DONAHUE | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 21 83 | | | 2b. HOUR 7:30 P.M. | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 20 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | 6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U-S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY D.C. Schools | | | |
| 13a. STATE D.C. | | | 13b. COUNTY | | 13c. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3343 P Street, N.W. 20016 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Matthew E. Donahue | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Keliher | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 579-60-3688 | |
| 17. INFORMANT Sister | | | ADDRESS 7714 Curtis Street | | | 17. INFORMANT Louise D. O'Connor | | | | ADDRESS Chevy Chase, Md. 20815 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROGRESSIVE CEREBROVASCULAR DISEASE 4049 DUE TO, OR AS A CONSEQUENCE OF (b) ART. I / CAR. REN. VAS. DIS. DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC BRAIN SYNDROME WITH SEIZURES | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MO YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC BRAIN SYNDROME WITH SEIZURES | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2/9 1974 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 2/9 1974 to 9/21 1983 , that (I) (we) last saw the deceased alive on 9/21 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Frederick W. Schneider MD | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9/21/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK W. SCHNEIDER | | | 22e. ADDRESS 201-8 ST NE DC 20002 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sep. 24, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Rood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | ADDRESS 500 University Blvd., W. Silver Spring, Md. | | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | 25b. REGISTRAR'S SIGNATURE John L. Lohr | | | |

Page 4
Faint handwritten notes and a large 'X' mark.

Handwritten notes at the bottom of the page, including a date '8-1-83' and a signature.

15

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25089 | |
|--|------------------|--|--|---|---|---|---|---|----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mannie Donaldson | | | | | | 7a. DATE KNOWN OF DEATH MONTH 9 DAY 17 YEAR 1983 | | 7b. HOUR 6:30 M PM | | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH Aug. DAY 23 YEAR 1899 | | 6. AGE (IN YEARS) LAST BIRTHDAY 84 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH 9 DAY 17 YEAR 1983 | | 7d. HOUR 6:30 M PM | | |
| 7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | 7f. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 408 Montgomery Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk-typist | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt | | | |
| 13a. STATE Md | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 408 Montgomery St. | | | |
| 14. FATHER'S NAME FIRST Robert MIDDLE Downing LAST Crider | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Susan MIDDLE Elizabeth LAST Bruce | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 577 05 8161 | | 17. INFORMANT William Crider | | ADDRESS 34 Holmehurst Ave Catonsville, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Angocardial infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: DO NOT WRITE AT WORK | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE SAID A. DABE MD | | | | M.D. Deputy | | MEDICAL EXAMINER | | DATE SIGNED 9-17-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis Rd | | | | ADDRESS Bladensburg MD 20710 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept 20, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park | | 23d. LOCATION CITY Dorsey , Maryland STATE | | | |
| 24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25090 | |
|--|--|----------------------|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Pinkey J. Dorsey | | | | | | | | | | 2a. DATE OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR 9 2 1983 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 2 DAY 2 YEAR 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | | 2c. DATE PRONOUNCED DEAD 9 3 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ✓ | | | 7b. CITIZEN OF WHAT COUNTRY? ✓ | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. | | |
| 10. CITY OR TOWN OF DEATH Fort Washington | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11406 Indian Head Highway | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY | | | 13c. CITY OR TOWN Fort Washington | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn. | | | 16b. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | | ADDRESS | | | 13e. STREET ADDRESS 11406 Inidan Head Hwy. | | | 20022 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth MD | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 9-4-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | | 23b. DATE 9/22/83 | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1983 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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Fort Washington

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
 STATE
 REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Parbhudas G DOSHI | | | 2a. DATE OF DEATH MONTH DAY YEAR September 9, 1983 | | | 2b. HOUR 4:52P M | | | |
| 3. SEX Male | | 4. RACE Indian | | 5. DATE OF BIRTH MONTH DAY YEAR Aug., 14, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) India | | 7b. CITIZEN OF WHAT COUNTRY? India | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dr.'s Hospital of P.G. County | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salemman | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Lanham | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 9716 Anita Lane Lanham, Md. 20801 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gangadas Doshi | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Manibai Doshi | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None | | 17. INFORMANT Kanu P. Doshi-son | | ADDRESS Md. 20801 9716 Anita Lane Lanham, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> 5185 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Respiratory Distress Syndrome</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>2 days</u> <u>9 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hepatic Encephalopathy, aspiration pneumonia, Renal failure, congestive heart failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> , 19 <u>83</u> , to <u>9/19</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Paul A DeVore</u> M.D. DEGREE | | | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN | | | | 22c. DATE SIGNED 9/5/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A DEVORE, MD | | | | 22e. ADDRESS 6525 BELCREST ROAD HYATTSVILLE MARYLAND 20782 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept 10, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002 | | | |
| 24. FUNERAL DIRECTOR Lee Funeral Home NAME ADDRESS 300-4th St. N.E. Washington, D.C. 20002 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | 25b. REGISTRAR'S SIGNATURE <u>J. C. Conish</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1944-1945

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|------------------------------|--|---|--|--------------------------------------|--|--|--|--|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2b. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| Rose B. Dressler | | | | September 10, 1983 | | | | 3:15 P.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 74 HRS | | | |
| Female | | White | | Sept. 23, 1907 | | 75 | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maine | | U.S.A. | | | | Prince George's County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Riverdale Heights | | | | 6304 61st. Ave. | | | | Cafeteria | | | | Schools G. Co. | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | Zip Code - | |
| Maryland | | | | P.G. | | Riverdale | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6304 61st. Ave. | | 20737 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Everett W. Quint, Sr. | | | | Ida Huff | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | 005-05-7459 | | Mrs. Norma C. Loeffel | | | | Address Same as No# 13e. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 1560 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Extrahepatic Biliary Obstruction</u> (c) <u>METASTATIC CARCINOMA OF Gallbladder</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u> <u>2-3 months</u> <u>1 1/2 years</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NONE</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> 19 <u>82</u> , to <u>9-10</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9-9</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| | | | | | | | | Sept. 12, 1983 | | | | | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22b. ADDRESS | | | | | | | | | |
| Ricardo Longoria, M.D. | | | | 6201 Greenbelt Road #M-17 College Park, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | Sept. 13, 1983 | | Ft. Lincoln Cemetery | | Brentwood P.G. Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | |
| F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | | | | | | | SEP 15 1983 John J. Conish | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: # Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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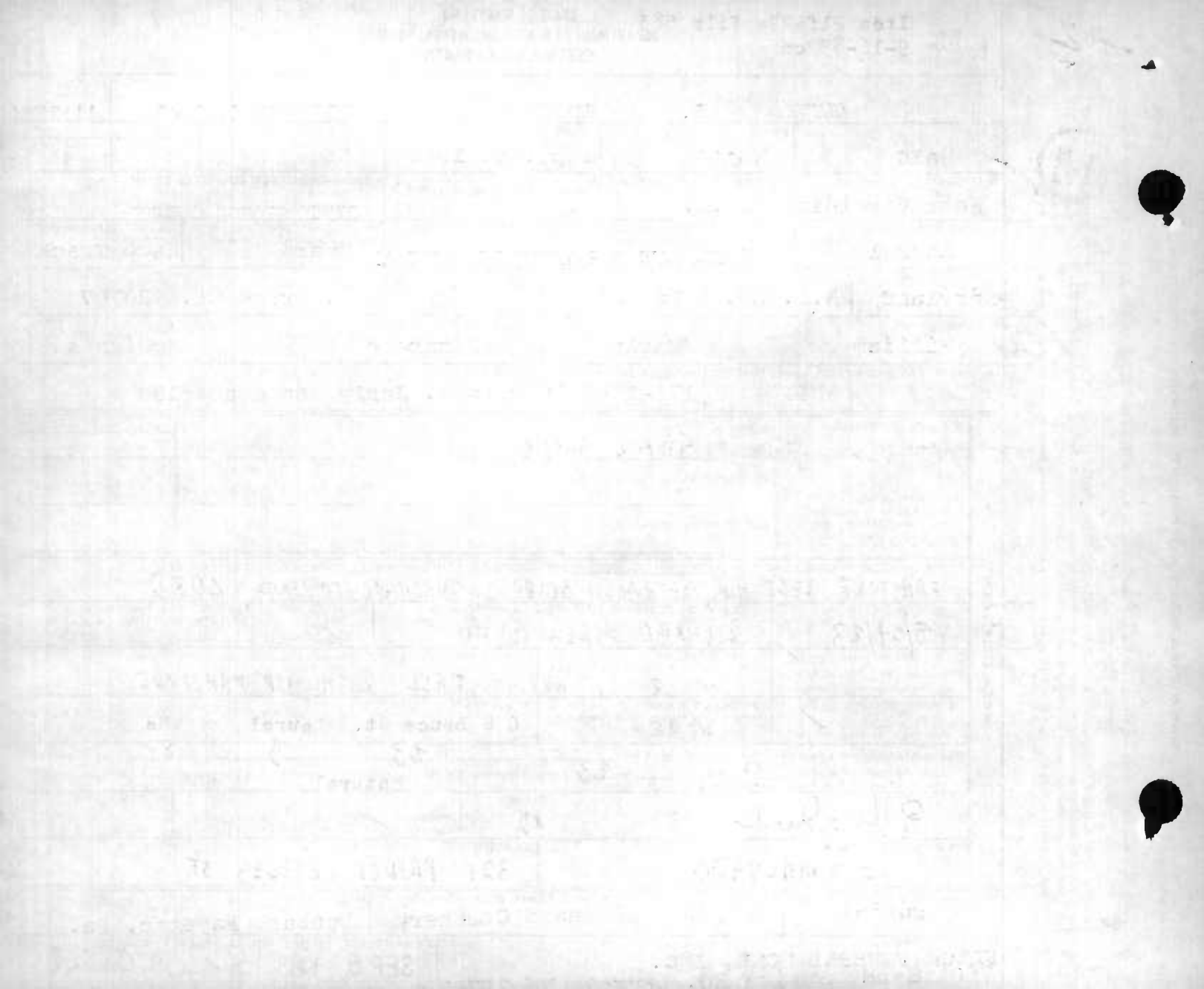
• *Journal of Management Education* 24(10):1139-1150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or an autopsy requested.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR FOR Itdm 21f&22a film 583 9-16-83 cn | | | | 25093 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) CLYDE, L. EARLY | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1, 1983 | | 2b. HOUR 11:20PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard | | 12b. KIND OF BUSINESS OR INDUSTRY Race Track | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Laurel | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Early | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth McGinnis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WWII | | 17. INFORMANT Nora V. Early | |
| | | | | ADDRESS same as #13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTIC SHOCK</u> <u>2762</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>FRACTURE LEFT HIP, METABOLIC ACIDOSIS, THROMBOCYTOPENIA COPD</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>8/24/83</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RICHARD STREW @ HIP</u> | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>8</u> <u>21</u> <u>1983</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) <u>FALL WITH HIP FRACTURE</u> | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>HOME</u> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>6 S Bruce St. Laurel Md</u> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-1</u> , 19 <u>83</u> , to <u>9</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9-1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Natural</u> | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | DEGREE <u>MD</u> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ES MACHADO</u> | | | | 22e. ADDRESS <u>321 PRINCE GEORGES ST</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>9/6/83</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Leonard Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Dunbar, Fayette, Pa.</u> | |
| 24. FUNERAL DIRECTOR <u>ELECK FUNERAL HOME, INC.</u> 7601 Sandy Spring Rd. Laurel, Md 20707 | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 6 1983</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|-------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE P. EBRON | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-29-83 | | 2b. HOUR MIN 3:10PM | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 12 25 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greenville, NC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Private | |
| 13a. STATE D.C. | | 13b. CITY OR TOWN Washington | | 13c. STREET ADDRESS 4704 Meade Street, N.E. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lonnie Perkins | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Wichard | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 246-09-3595D | | 17. INFORMANT ADDRESS (Daughter) Alice Jones 4704 Meade St. NW WashDC | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3940 IMMEDIATE CAUSE (a) Pulmonary Hypertension DUE TO, OR AS A CONSEQUENCE OF: (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) Due to, or as a consequence of: | | | | | | | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Arteriosclerosis, chronic insuff. Congestive Heart Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-19-82 to 9-29-83 , that (I) (we) last saw the deceased alive on 9-29-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Thomas Perkins | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-29-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Perkins | | 22e. ADDRESS 9470 Annapolis Rd Lanham MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE Sept/30/83 | | 23c. NAME OF CEMETERY OR CREMATORY Church Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Greenville N.C. | |
| 24. FUNERAL DIRECTOR NAME R.N. Horton Co. Mort. Inc. | | ADDRESS (WashDC) 600 Kennedy St. NW | | 25a. DATE REC'D. BY REGISTRAR OCT 4 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2:30PM

04-23-02

LEAVE

11

ALICE

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSP.

CHEVREY

100%

COLLECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "or," item 18 shows any injury, or other traumatic event, the medical examiner must be notified on item 1, once.

| Item 8, Film#G584 - FOR STATE REGISTRAR 10/13/83jlb | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 25095 | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arline C. Elliott | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 25, 1983 | | | | 2b. HOUR 7:24 P.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR January 31, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 0 0 | | 7. IF UNDER 24 HRS. HOURS MIN. 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Bladensburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5301 Quincy Street #301 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Craven | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Lee | | | | 16. ADDRESS Address Same as No# 13e. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 261-05-8571 | | 17. INFORMANT Mr. Ross A. Elliott | | | | 18. ADDRESS Address Same as No# 13e. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4920 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) pneumonia LLL DUE TO, OR AS A CONSEQUENCE OF (c) pulmonary embolism | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 7, 1983 to Sept 25, 1983 , that (I) (we) saw the deceased alive on Sept 21, 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Don B. Cameron | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED Sept. 27, 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don B. Cameron, M.D. | | | | 22e. ADDRESS 6490 Landover Road - Cheverly, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept. 28, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. | | | | ADDRESS Hyattsville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE John J. [Signature] | | | | | | | | | | | |

1. Name of the person or organization to whom the letter is addressed.
 2. Address of the person or organization to whom the letter is addressed.
 3. City, State, and Zip Code of the person or organization to whom the letter is addressed.
 4. Date of the letter.
 5. Salutation (e.g., Dear Sir, Dear Madam, Dear Mr. Smith).
 6. Body of the letter (the main text).
 7. Closing (e.g., Sincerely, Very truly yours, Respectfully).
 8. Signature of the person sending the letter.
 9. Name and Title of the person sending the letter.
 10. Address of the person sending the letter.
 11. City, State, and Zip Code of the person sending the letter.
 12. Enclosure (if any).
 13. Postage (if any).
 14. Return Address (if any).
 15. Other information (if any).

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the deceased, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|---|---|---|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William Elliott | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 25 1983 | | | | | 2b. HOUR 8:40 PM | |
| 3. SEX male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR July 01 1942 | | 6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH ANDREWS AFB | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EDUC. SUPER. | | 12b. KIND OF BUSINESS OR INDUSTRY MILITARY | | | |
| 13a. STATE MARYLAND | | | | | 13b. COUNTY PRINCE GEORGE'S | | 13c. CITY OR TOWN CLINTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST OLIVER ENNOLS | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JUANITA POTTER | | | | | 13e. STREET ADDRESS 5006 MEGAN DR. (20735) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1961-1983 | | 17. INFORMANT ADDRESS 5006 MEGAN DR. JOANN ELLIOTT, CLINTON, MD. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Adenocarcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 25 Sept 19 83 to 25 Sept 19 83 , that (I) (we) lost saw the deceased alive on 25 Sept 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE DDye MD | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 25 Sept 83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH Douglas Dye | | | | | | 22e. ADDRESS MALCOLM GROW USAF MED CEN AAFB, MD 20331 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE September 29, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia | | | | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. | | | | | | 25a. DATE REC'D BY REGISTRAR SEP 27 1983 | | 25b. REGISTRAR'S SIGNATURE John J. [Signature] Atch 3 | | | |
| 24. FUNERAL DIRECTOR ADDRESS Old Alexander Ferry Road, Clinton, Maryland | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

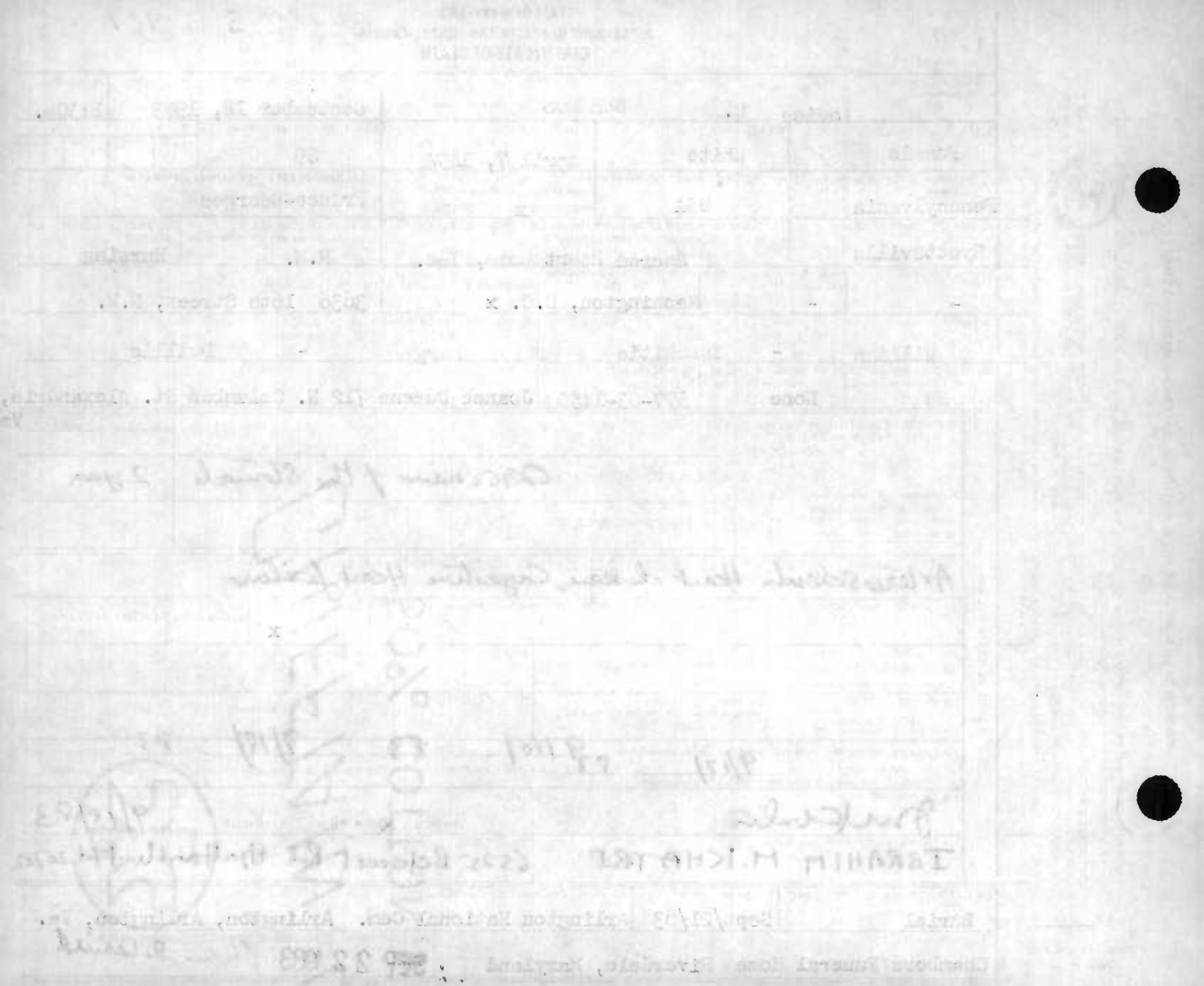
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louise C. EURKOOS | | | 2a. DATE OF DEATH MONTH DAY YEAR September 18, 1983 | | 2b. HOUR 1:30p.m. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR April 7, 1894 | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges MD. | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) R.N. | 12b. KIND OF BUSINESS OR INDUSTRY Nursing | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY - - | | 13c. CITY OR TOWN Washington, D.C. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 3636 16th Street, N.W. 99999 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William - Yanchitis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - Dwillis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. None 577-03-1450 | 17. INFORMANT ADDRESS Joanne Dumene 712 N. Columbus St. Alexandria, Va. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Carcinoma of the Stomach 2 year (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic heart disease, congestive heart failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/10/83, 1983, to 9/18/83, 1983, that (I) (we) lost saw the deceased alive on 9/17/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/18/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) IBRAHIM M. KHATRI | | 22e. ADDRESS 6525 Belcrest Rd Hyattsville Md 20782 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Sept/21/83 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington, Va. | |
| 24. FUNERAL DIRECTOR NAME Chambers Funeral Home | | ADDRESS Riverdale, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | 25b. REGISTRAR'S SIGNATURE [Signature] |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| FOR Item 21a thru 22a 1- STATE REGISTRAR film 585 11-10-83 cn | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CALVIN Elsworth FAIRALL | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 24 83 | | 2b. HOUR 1:00P M | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 16 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY Navy yard | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 909 Montgomery Str. 20707 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John --- Fairall | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora --- Beall | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT Catherine Fairall | | ADDRESS Same as #13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10 CARCINOMA LARYNX, TRACHEOSTOMY, ALCOHOL ABUSE, FRACTURE LEFT HIP | | | | | | | | | |
| 19a. DATE OF OPERATION 9/11/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE LEFT HIP | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Neither | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 3 83 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Fall | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 909 Montgomery St. Laurel Md | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/24 Sept 19 83, to 9/24 Sept 19 83, that (I) (we) lost saw the deceased alive on 9/24 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural | | | | | | | | | |
| 22b. SIGNATURE E. S. Malchado | | | | 22c. DATE SIGNED 9/24/83 | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESMALCHADO | | | | 22e. ADDRESS 321 PRINCE GEORGE ST LAUREL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 28 Sept 83 | | 23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md. | | | |
| 24. FUNERAL DIRECTOR FLECK FUNERAL HOME INC 7601 sandy spring Rd. Laurel Md. 20707 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Cahill | | | |

Blackburn and Sons

1855



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|--|---|---|---|--------------------------------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) George Wellington FALLIN | | | 2a. DATE OF DEATH MONTH DAY YEAR September 18, 1983 | | | 2b. HOUR 2:15am | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR August 10 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hosp. of Pr. Geo. Co. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter - GPO | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't. | | |
| 13a. STATE Maryland | | | 13b. COUNTY Prince George Oxon Hill | | 13c. CITY OR TOWN Oxon Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Enos H. Fallin | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura E. Douglas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 678-36-4741 | | 17. INFORMANT ADDRESS Lorena G. Fallin 1316 Dunwoody Avenue Oxon Hill, Maryland | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Cervical Carcinoma | | APPROXIMATE INTERVAL BETWEEN (a) AND DEATH 1 hr 1 hr | |
|--|--|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/15/83 to 9/18/83, that (I) (we) lost saw the deceased alive on 9/15/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE MARTIN D. WERTZ | | DEGREE ATTENDING PHYSICIAN | | MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept. 18, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN D. WERTZ | | 22e. ADDRESS 7676 New Hampshire Ave | | | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home | | | | ADDRESS 1610 Oxon Hill Rd Oxon Hill, Md. | | 25. DATE REC'D. BY REGISTRAR SEP 22 1983 | |
| REGISTRAR'S SIGNATURE John J. Church | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY



Male

Washington

Virginia

U.S.A.

Printer - Geo. W. Gault, Inc.

1110 Broadway Avenue

1110 Broadway Avenue, New York City

Design

William

Photo

1110 Broadway Avenue
New York City, N.Y.

George C. Allen

828-36-1111

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George C. Allen
1110 Broadway Avenue
New York City, N.Y.

1110 Broadway Avenue
New York City, N.Y.

1110 Broadway Avenue
New York City, N.Y.

1110 Broadway Avenue
New York City, N.Y.

Geo. W. Gault, Inc.

Design

William

George C. Allen
1110 Broadway Avenue
New York City, N.Y.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

| Item # Info | | | | | | | | | | STATE OF MARYLAND | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 25100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | Film G585 11/3/83, MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | FIRST FLORENCE MIDDLE L. LAST Farmer | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | MONTH 9 DAY 28 YEAR 83 | | | | | | | | | | 2b. HOUR 19 M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX female | | | | | | | | | | 4. RACE white | | | | | | | | | | 5. DATE OF BIRTH 9-22-92 | | | | | | | | | | 6. AGE (IN YEARS BIRTHDAY) 91 YRS. | | | | | | | | | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | | | | | | | | | 7c. DATE PRONOUNCED DEAD 9-29 19 83 | | | | | | | | | | 7d. HOUR 12:30 M | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Fort Washington | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 6606 Farmer Drive | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Md. | | | | | | | | | | 13b. COUNTY P.G. | | | | | | | | | | 13c. CITY OR TOWN Temple Hills | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 6606 Farmer Drive 20748 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Herbert T. Caddick | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise E. Wiewert Siewert | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. None | | | | | | | | | | 17. INFORMANT ADDRESS Alexandria, Va. 22307 | | | | | | | | | | 17b. Carl Birckner-son in law 1205 Huntley Pl. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4292 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | 22b. TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | | | | | | | DATE 9-29-83 SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | | | | | | | EXAMINER'S NAME AUGUSTO P. RODRIGUEZ M.D. | | | | | | | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. 20748 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE Oct 1, 1983 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home | | | | | | | | | | ADDRESS 300-4th St. N.E. Wash. D.C. 20002 | | | | | | | | | | OCT 6 1983 REGISTRAR SIGNATURE John J. Linder | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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Interests

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Harold T. Fredrick

Page 10

Levin, A. V., & SSS

1941-1942

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100-443887-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 83 25101 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William T. Farrell | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 7, 1983 | | 2b. HOUR 11:00 A.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 1, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3302 Chesapeake Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY Wash. Terminal | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Pr. Geo.'s | | 13c. CITY OR TOWN Hyattsville | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Farrell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Army | | 16b. SOCIAL SECURITY NO. Peacetime 719-16-3117 | | 17. INFORMANT ADDRESS Address Same as No# 13e. Mrs. Josephine C. Farrell | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic Stenosis (c) Atherosclerotic Coronary Artery Disease 14 yrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-12 , 19 83 , to 9-1 , 19 83 , that (I) (we) lost saw the deceased alive on 5-1 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Craig Jeschke, MD | | | | DEGREE MD | | 22c. DATE SIGNED 9-7-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Craig Jeschke, MD | | | | 22e. ADDRESS Owings, MD 20736 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons, PA Hyattsville, Md. | | | | 25. DATE REC'D BY REGISTRAR 26. REGISTRAR'S SIGNATURE SEP 13 1983 John J. Carver | | | |

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LOGE, J. J. 1974

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.
Croner notified and approved

MEDICAL CERTIFICATION

| FOR 1. STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 25102 REG. NO. | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruby A. Fiedler | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 19, 83 | | | | 2b. HOUR MIN. 12:24 PM | | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 9 9 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Pr. George | | 13c. CITY OR TOWN Cap. Hgts. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7308 Walker Mill Rd. 20743 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willard Bishop | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby Lyon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 578-12-3496 | | 17. INFORMANT ADDRESS David M. Fiedler same as item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Lung with metastases DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Obstructive Lung Disease; Diabetes Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/4 19 83 to 9 19 83 , that (I) (we) lost saw the deceased alive on 5/4 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE L.V. Kaufman | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/21/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis V. Kaufman, M.D. | | | | 22e. ADDRESS 10905 Ft. Wash. Rd., Ft. Wash., Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/24/83 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md. | | | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home | | | | ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md. | | DATE RECEIVED BY REGISTRAR SEP 26 1983 | | REGISTRAR'S SIGNATURE John J. Amick | | | |

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George F. Kellan, Attorney at Law, 1000 Broadway, New York, N.Y.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25103

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward Joseph FITZPATRICK | | | 2a. DATE OF DEATH MONTH DAY YEAR September 14, 1983 | | 2b. HOUR 7:35 P.M. |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 12, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | |
| 10. CITY OR TOWN OF DEATH LANHAM | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G.Co. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER | 12b. KIND OF BUSINESS OR INDUSTRY CONCRETE CO. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. COUNTY P.G. CO. | 13c. CITY OR TOWN LANDOVER | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 7117 BUCHANAN STREET |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM J. FITZPATRICK | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY A. HURNEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO NONE | | 16b. SOCIAL SECURITY NO. 577-28-1849 | | 17. INFORMANT ADDRESS LARRY FITZPATRICK (SON) 171 RIVERSIDE DRIVE ORMOND BEACH, FLORIDA | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastasis to Left Pleura</u> (c) <u>Metastasis to Bone.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>14 Sept. 1983</u> to <u>14 Sept. 1983</u> , that (I) (we) lost saw the deceased alive on <u>14 Sept. 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not see the body after death. | | | | | |
| 22b. SIGNATURE <u>Thomas Maloney</u> | | DEGREE MD | | 22c. DATE SIGNED <u>15 Sept. 83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS MALONEY, M.D. | | 22e. ADDRESS 4814 - 71st Avenue, Hyattsville, Md. 20784 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | 23b. DATE SEPT. 15, 1983 | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G.CO. MARYLAND | |
| 24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME | | ADDRESS RIVERDALE, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Medical Examiner Notified & Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a

MEDICAL CERTIFICATION

| FOR 1. STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25104 | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Sheree L. Fikes | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 13, 1983 | | | | 2b. HOUR 5:00p | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 27, 1955 | | 6. AGE (IN YEARS LAST BIRTHDAY) 28 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD | | | | | |
| 10. CITY OR TOWN OF DEATH Greenbelt | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) 8 Q Plateau Place | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Legal | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN Greenbelt | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13. STREET ADDRESS 8 Q Plateau Place 20770 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Allan Fikes | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Lowry | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 70 2915 | | 17. INFORMANT ADDRESS JoAnn Ellifritz Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Breast carcinoma, metastatic | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH three years | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from December 1981 , to September 1983 , that (I) (we) lost saw the deceased alive on September 6 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Scott D. Rowley M.D. | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Scott D. Rowley | | | | 22e. ADDRESS Johns Hopkins Oncology Center, Baltimore Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | | 23b. DATE 9/16/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Francis Casch's Sons Funeral Home, P.A. | | | | | | ADDRESS Hyattsville, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Casch | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must file.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|---|--|-------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| FIRST MABEL | | | MONTH DAY YEAR | | | 12:48a | | | |
| MIDDLE A. | | | September 13, 1983 | | | M | | | |
| LAST FITZGERALD | | | | | | | | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | |
| FEMALE | | | WHITE | | | Aug. 9, 1907 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | |
| Pennsylvania | | | U.S.A. | | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| Prince George | | | Leland Memorial Hospital | | | Housewife | | | |
| 13a. STATE | | | 13b. INSIDE CITY LIMITS? | | | 13c. STREET ADDRESS | | | |
| Maryland | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 5114 Edgewood Road 20740 | | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | |
| George | | | Mary | | | Haley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT | | | |
| No | | | 159 18 5469 | | | ADDRESS 5114 Edgewood Rd. | | | |
| | | | | | | Regina M. Seitz College Park, Md. 20740 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/5/1981</u> to <u>12/16/1982</u> , that (I) (we) last saw the deceased alive on <u>12/16/1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| <u>Azher Hussain</u> | | | | | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 9/13/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| Azher Hussain, M.D. | | | | | 4917 Edgewood Road College Park, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Cremation | | | Sept. 14, 1983 | | Ft. Lincoln Crematory | | Brentwood P.G. Maryland | | |
| 24 FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | |
| NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| | | | | | SEP 19 1983 <u>[Signature]</u> | | | | |



789 10 603 2-2-20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|---|---|-------------------|--|--|---|---|-----------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| FRANK | | L. | | FITZPATRICK | 9 | 14 | 83 | | 3:30A.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | White | May 22, 1899 | | 84 | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Illinois | U.S.A. | | | PRINCE GEORGE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CHEVERLY | PG GENERAL HOSPITAL | | | Ret. Printer | | G.P.O. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Maryland | | Prince Geo. | Mt. Rainier | | | 3101 Varnum Street 20712 | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| Thomas | | Fitzpatrick | Mary | | Brown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 328 09 5199 | | Hallie Fitzpatrick Same as #13 (Wife) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Respiratory Arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe advanced Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myocardial Infarction</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>① Pulmonary Infection ② chronic Cor Pulmonale</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>9-13-</u> 19 <u>83</u> , to <u>9-14-</u> 19 <u>83</u> , that (I) <u>was</u> lost saw the deceased alive on <u>9-13-</u> 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> <u>did not</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>S.C. ARYANGAT, MD</u> | | | | DEGREE | | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| S.C. ARYANGAT, MD | | | | 3308 PERRY ST. MT. RAINIER, MD 20712 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIUM | | 23d. LOCATION CITY OR TOWN | | STATE | |
| Burial | | 9/16/83 | | National Memorial Park | | Falls Church | | Va. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| SEP 16 1983 | | | | | <u>John J. Connel</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Printed by the Government Printer, Ottawa.

References

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CHAPTER 1

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STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE F. FLETCHER | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 11 1983 | | 2b. HOUR 2:15AM |
| 3. SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR DEC 10, 1923 | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 59 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH LAUREL | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPPLY FOREMAN | 12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE MARYLAND | 13b. COUNTY PRINCE GEO. | 13c. CITY OR TOWN BELTSVILLE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 11404 QUEEN ANNE AVE., 20705 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE A. FLETCHER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST STELLA DOVE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO | | 16b. SOCIAL SECURITY NO. 578-32-4140 | 17. INFORMANT ADDRESS GERTRUDE J. FLETCHER SAME AS 13 WIFE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden cardiac death 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Ileus, etiology undetermined | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/9 , 19 83 , to 9/11 , 19 83 , that (I) (we) lost saw the deceased alive on 9/10 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Barry K. Lance | | DEGREE M.D. | | 22c. DATE SIGNED 9/11/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry K. Lance, M.D. | | 22e. ADDRESS 14201 Laurel Park Dr., Suite 223, Laurel | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL | 23b. DATE 9/14/83 | 23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH CEMETERY | 23d. LOCATION CITY OR TOWN COUNTY STATE AMMENDALE PRI GEO MD. | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1983 | | |
| | | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|---|---|-----------------------------|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) PEARLE L. FORD | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-09-83 | | 2b. HOUR 3:44 PM | | | | | | |
| 1. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR July 4, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Lanham | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 10106 Annapolis Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Budd | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mucey | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown | | 17. INFORMANT Brenda Chase-7117 Kentown Dr. | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Possible GI bleed = aspiration</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Surgery for advanced Sarcoma of</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>tissues.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Chronic HYP, Distal Metastases</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>Sept 7, 1983</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Sarcoma of tissues</i> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/3</i> 19 <i>83</i> , to <i>9/7</i> 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>9/7</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>G. S. Rein, M.D.</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <i>9/12/83</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. S. REIN, M.D.</i> | | 22e. ADDRESS <i>PGGH + MC</i> | | | | | | | | | |
| 23a. BURIAL CREMATION REMOVAL (SPECIFY) | | 23b. DATE <i>9/13/83</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>LEE CREMATORY</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>WASHINGTON, D.C.</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>H. S. WASHINGTON SONS</i> | | | | ADDRESS <i>4925 - 15 UNKLOUGHER AVE.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 26 1983</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

| | | |
|----------|----------------------------------|------------------------|
| PEARL | 11-00-23 | 3:00 PM |
| CHERRY | PRINCE GEORGE'S GENERAL HOSPITAL | PRINCE GEORGE'S COUNTY |
| 11-00-23 | 3:00 PM | |

Handwritten notes:
 11-00-23
 3:00 PM



Vertical handwritten text:
 11-00-23
 3:00 PM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25109 | |
|---|--|-----------------------------|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ervin Joseph Frank | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 14 19 83 | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 18 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 14 19 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | |
| 10. CITY OR TOWN OF DEATH Oxon Hill | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5019 Glassmanor Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Army | | 12b. KIND OF BUSINESS OR INDUSTRY Military | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Pr. George | | 13c. CITY OR TOWN Oxon Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5019 Glassmanor Dr. 20745 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest L. Frank | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen T. Kesterman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. Korea-Viet Nam 289-24-8188 | | 17. INFORMANT ADDRESS Elizabeth A. Frank same as item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 4029 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | TITLE (SPECIFY) Deputy M.D. | | | | DATE SIGNED 9/14/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez | | | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Veteran Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md. | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | | | | |
| ADDRESS 6160 Oxon Hill Rd. Oxon Hill, MD | | | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i> | | | | | |

1. Frank ...
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25110

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--------------|-----------------|---|--|--|---|---|-----------------|-------------------------------|--|--|--|---|------------|---|-------------------|--|--|---|------------|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Harold | | | MIDDLE F. | | | LAST Freeman | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | MONTH 9 | | | DAY 24 | | | YEAR 83 | | | 7b. HOUR 10:37 | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR April 21, 1903 | | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 80 YRS. | | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 24 83 | | | 2d. HOUR 10:37 | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | 12b. KIND OF BUSINESS Unemployed Government | | | | | | | | | | | |
| 13a. STATE Maryland | | | | | | | | | | | | 13b. CITY OR TOWN Prince George's | | | | 13c. CITY OR TOWN Hyattsville | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 4801 Glenoak Rd 20784 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick L. Freeman | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Dwyer | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-2340 | | | | | | 17. INFORMANT ADDRESS Kathlyn P. Freeman 4801 Glenoak Road Hyattsville, MD 20784 | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertens</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN CHEST AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dr. Said A. Dace, M.D. | | | | | | TITLE (SPECIFY) Deputy | | | | | | MEDICAL EXAMINER | | | | | | DATE SIGNED 9-25-83 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) 5682 annapolis Rd | | | | | | ADDRESS Bladensburg MD 20710 | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | 23b. DATE Sept 28, 1983 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. George's, MD | | | | | | | | | |
| 24. FUNERAL HOME NAME Beall Funeral Home | | | | | | ADDRESS 16000 Annapolis Road Bowie, Maryland 20715 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1983 | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Lohr | | | | | | | | | |

RECEIVED
FEB 20 1968

20

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]

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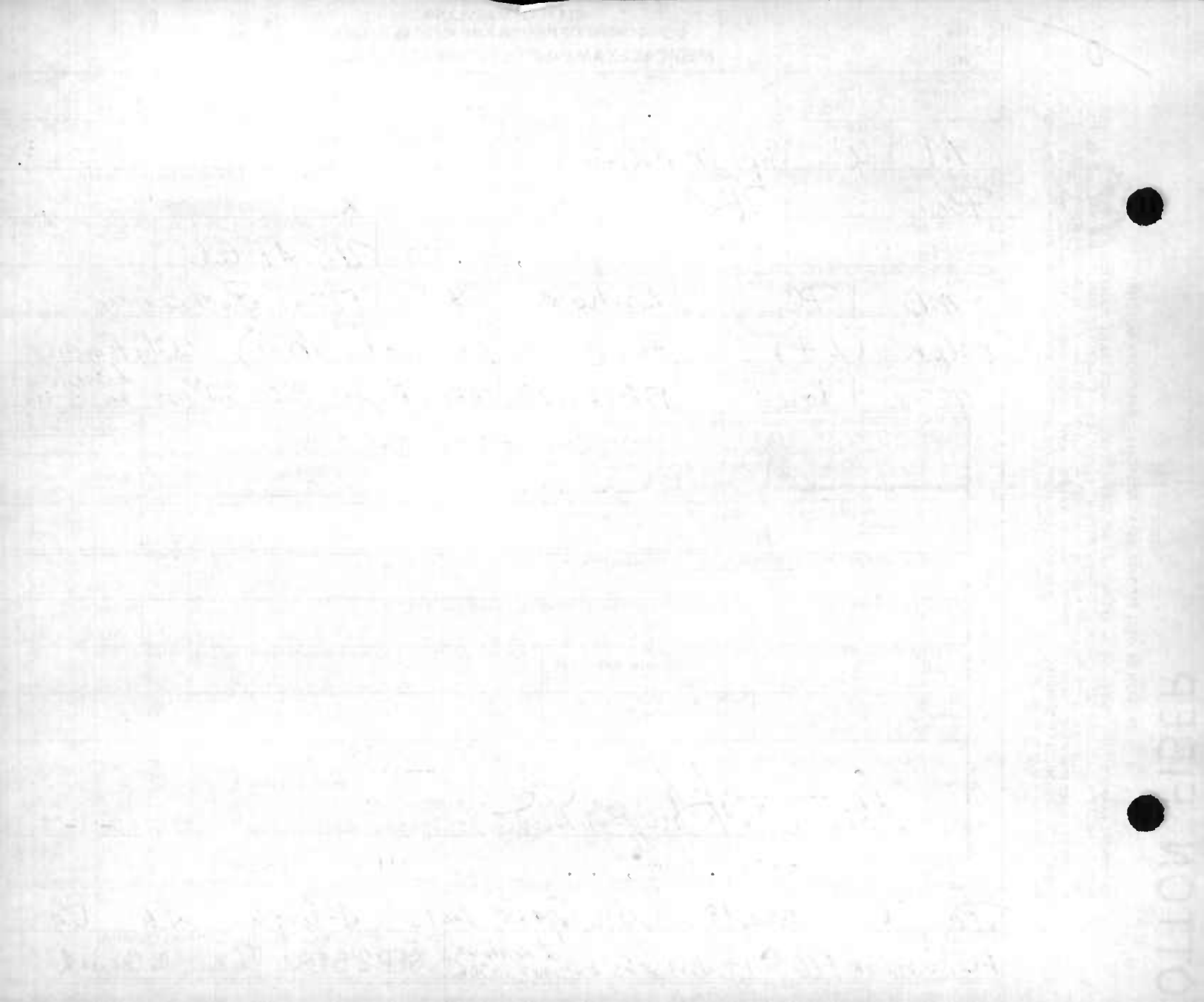
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25111 REG. NO. | | | | | | | | | | | | | | | | | | | | | |
|---|--|-----------|--|--|--|---|--|--|--|--|--|-----------------------|--|--------------------------|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Thomas E. Furr | | | | | | | | | | MONTH DAY YEAR 9 19 1983 | | 2b. HOUR 5:40 P.M. | | | | | | | | | | | | | | | | | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH (MONTH DAY YEAR) Sept 20 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD 9 20 1983 | | 2d. HOUR 5:40 P.M. | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN | | | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7521 Buchanan Street, Apt. 137 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) U.S. AF Lt. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. STATE MD | | 13b. CITY OR TOWN PG. | | 13c. CITY OR TOWN Lanham | | 13d. INNOV. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7521 Buchanan | | | | | | | | | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Ralph (NA) Furr | | | | | | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Margaret (NA) Whitman | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES | | | | | | | | | | 16b. SOCIAL SECURITY NO. 194-16-6129 | | | | | | | | | | 17. INFORMANT NAME AND ADDRESS Maria Bryant 3802 72nd Ave Lanover H. 715 MD | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth M.D. | | | | | | | | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 9-21-83 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | | | | | | | ADDRESS 111 Penn Street | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 23 Sept 83 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arl. VA. | |
| 24. FUNERAL DIRECTOR NAME Flats/Lanham E.H. 9013 Amgols Rd Lanham MD 20706 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|--------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | | | | | |
| MAURICE F. GAHAN | | | | SEPTEMBER 19 1983 | | | | 12:00 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| MALE | | WHITE | | MONTH DAY YEAR | | 92 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| PENNSYLVANIA | | UNITED STATES | | | | PRINCE GEORGES MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| LANHAM | | MAGNOLIA GARDENS NURSING HOME | | Ret. Civil Engineer-U.S. Gov | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20781 #102 | | | |
| MARYLAND PRINCE GEORGE HYATTSVILLE | | | | | | | | 5118 EDMONSTON ROAD (20781) | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Maurice F. Gahan | | | | Margaret Cronin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | | | 100-10-7891 | | MARGARET BEHEN-HYATTSVILLE | | 5118 EDMONSTON ROAD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Progressive Dementia - probable Alzheimer years | | | | | | | | | | | |
| 2901 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/30 1983, to 9/19 1983, that (I) (we) lost saw the deceased alive on 9/16 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Don H. Yablonski | | | | M.D. | | | | 9/19/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Don H. Yablonski MD | | | | 10200 Greenbelt Rd, Seatonsville, MD 20706 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATOR | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 9/24/1983 | | Calvary Mem. Cem. | | Fairfax Fairfax Va. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Nalley's F.H. Inc. | | | | Mt. Rainier, Maryland | | | | SEP 28 1983 Sam J. Carver | | | |

17

100-10-1001

CHIEF

SOXICULTO



100-10-1001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25113 REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) KEVIN GALE | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9 17 19 83 | |
| 3. SEX Male 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR Nov. 15 62 6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS. 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 17 19 83 | | | | | | | | | | 2b. HOUR 12:35 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County | | | | | | | | | | 2d. HOUR 12:35 | |
| 10. CITY OR TOWN OF DEATH Cheverly 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed 12b. KIND OF BUSINESS OR INDUSTRY ----- | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE MD. 13b. COUNTY P.G. 13c. CITY OR TOWN Landover 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3211 75th Ave. #1 | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur Gale 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Jordan | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. Not Stated 17. INFORMANT ADDRESS Arthur Gale (Father) | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7580 IMMEDIATE CAUSE (a) Down's syndrome and obesity DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 9-18-83 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 23 Sept 83 23c. NAME OF CEMETERY OR CREMATORY Harmony MEM. Cemetery Landover, MD. 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME FRAZIER'S FUNERAL S ADDRESS N.W. WASHINGTON 389 Rhode Island Ave 25a. DATE REC'D. BY REGISTRAR SEP 29 1983 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | |



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED



LOW-FIBER
DIN 1000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Bernard Francis Gallagher | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 4, 1983 | | | 2b. HOUR 5:30 ^A _M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 9 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Keeper - National Zoo | |
| 13a. STATE Md. | | 13b. COUNTY PG | | 13c. CITY OR TOWN Forestville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard Francis Gallagher, Sr | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie K. Robertson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 224-14-5651 | | 17. INFORMANT ADDRESS Louise Gallagher, Wife, Same as Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO Pulmonary Arrest 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF The BLADDER DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 m.w. 15 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 9/3</u> , 19 <u>82</u> to <u>9/3</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/3</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Charles F. Colao | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9/4/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Colao, M.D. | | | | 22e. ADDRESS 3710 Riviera St., Marlow Hgts, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-8-83 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Natl. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland | |
| 24. FUNERAL DIRECTOR NAME Robt E Wilhelm | | | | ADDRESS 4308 Suitland Rd., Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

| Item | | Description | | Quantity | | Unit Price | | Total Price | |
|------|--|-------------|--|----------|--|------------|--|-------------|--|
| 1 | | Item 1 | | 10 | | 100 | | 1000 | |
| 2 | | Item 2 | | 5 | | 200 | | 1000 | |
| 3 | | Item 3 | | 15 | | 50 | | 750 | |
| 4 | | Item 4 | | 20 | | 30 | | 600 | |
| 5 | | Item 5 | | 10 | | 100 | | 1000 | |
| 6 | | Item 6 | | 5 | | 200 | | 1000 | |
| 7 | | Item 7 | | 15 | | 50 | | 750 | |
| 8 | | Item 8 | | 20 | | 30 | | 600 | |
| 9 | | Item 9 | | 10 | | 100 | | 1000 | |
| 10 | | Item 10 | | 5 | | 200 | | 1000 | |
| 11 | | Item 11 | | 15 | | 50 | | 750 | |
| 12 | | Item 12 | | 20 | | 30 | | 600 | |
| 13 | | Item 13 | | 10 | | 100 | | 1000 | |
| 14 | | Item 14 | | 5 | | 200 | | 1000 | |
| 15 | | Item 15 | | 15 | | 50 | | 750 | |
| 16 | | Item 16 | | 20 | | 30 | | 600 | |
| 17 | | Item 17 | | 10 | | 100 | | 1000 | |
| 18 | | Item 18 | | 5 | | 200 | | 1000 | |
| 19 | | Item 19 | | 15 | | 50 | | 750 | |
| 20 | | Item 20 | | 20 | | 30 | | 600 | |
| 21 | | Item 21 | | 10 | | 100 | | 1000 | |
| 22 | | Item 22 | | 5 | | 200 | | 1000 | |
| 23 | | Item 23 | | 15 | | 50 | | 750 | |
| 24 | | Item 24 | | 20 | | 30 | | 600 | |
| 25 | | Item 25 | | 10 | | 100 | | 1000 | |
| 26 | | Item 26 | | 5 | | 200 | | 1000 | |
| 27 | | Item 27 | | 15 | | 50 | | 750 | |
| 28 | | Item 28 | | 20 | | 30 | | 600 | |
| 29 | | Item 29 | | 10 | | 100 | | 1000 | |
| 30 | | Item 30 | | 5 | | 200 | | 1000 | |
| 31 | | Item 31 | | 15 | | 50 | | 750 | |
| 32 | | Item 32 | | 20 | | 30 | | 600 | |
| 33 | | Item 33 | | 10 | | 100 | | 1000 | |
| 34 | | Item 34 | | 5 | | 200 | | 1000 | |
| 35 | | Item 35 | | 15 | | 50 | | 750 | |
| 36 | | Item 36 | | 20 | | 30 | | 600 | |
| 37 | | Item 37 | | 10 | | 100 | | 1000 | |
| 38 | | Item 38 | | 5 | | 200 | | 1000 | |
| 39 | | Item 39 | | 15 | | 50 | | 750 | |
| 40 | | Item 40 | | 20 | | 30 | | 600 | |
| 41 | | Item 41 | | 10 | | 100 | | 1000 | |
| 42 | | Item 42 | | 5 | | 200 | | 1000 | |
| 43 | | Item 43 | | 15 | | 50 | | 750 | |
| 44 | | Item 44 | | 20 | | 30 | | 600 | |
| 45 | | Item 45 | | 10 | | 100 | | 1000 | |
| 46 | | Item 46 | | 5 | | 200 | | 1000 | |
| 47 | | Item 47 | | 15 | | 50 | | 750 | |
| 48 | | Item 48 | | 20 | | 30 | | 600 | |
| 49 | | Item 49 | | 10 | | 100 | | 1000 | |
| 50 | | Item 50 | | 5 | | 200 | | 1000 | |
| 51 | | Item 51 | | 15 | | 50 | | 750 | |
| 52 | | Item 52 | | 20 | | 30 | | 600 | |
| 53 | | Item 53 | | 10 | | 100 | | 1000 | |
| 54 | | Item 54 | | 5 | | 200 | | 1000 | |
| 55 | | Item 55 | | 15 | | 50 | | 750 | |
| 56 | | Item 56 | | 20 | | 30 | | 600 | |
| 57 | | Item 57 | | 10 | | 100 | | 1000 | |
| 58 | | Item 58 | | 5 | | 200 | | 1000 | |
| 59 | | Item 59 | | 15 | | 50 | | 750 | |
| 60 | | Item 60 | | 20 | | 30 | | 600 | |
| 61 | | Item 61 | | 10 | | 100 | | 1000 | |
| 62 | | Item 62 | | 5 | | 200 | | 1000 | |
| 63 | | Item 63 | | 15 | | 50 | | 750 | |
| 64 | | Item 64 | | 20 | | 30 | | 600 | |
| 65 | | Item 65 | | 10 | | 100 | | 1000 | |
| 66 | | Item 66 | | 5 | | 200 | | 1000 | |
| 67 | | Item 67 | | 15 | | 50 | | 750 | |
| 68 | | Item 68 | | 20 | | 30 | | 600 | |
| 69 | | Item 69 | | 10 | | 100 | | 1000 | |
| 70 | | Item 70 | | 5 | | 200 | | 1000 | |
| 71 | | Item 71 | | 15 | | 50 | | 750 | |
| 72 | | Item 72 | | 20 | | 30 | | 600 | |
| 73 | | Item 73 | | 10 | | 100 | | 1000 | |
| 74 | | Item 74 | | 5 | | 200 | | 1000 | |
| 75 | | Item 75 | | 15 | | 50 | | 750 | |
| 76 | | Item 76 | | 20 | | 30 | | 600 | |
| 77 | | Item 77 | | 10 | | 100 | | 1000 | |
| 78 | | Item 78 | | 5 | | 200 | | 1000 | |
| 79 | | Item 79 | | 15 | | 50 | | 750 | |
| 80 | | Item 80 | | 20 | | 30 | | 600 | |
| 81 | | Item 81 | | 10 | | 100 | | 1000 | |
| 82 | | Item 82 | | 5 | | 200 | | 1000 | |
| 83 | | Item 83 | | 15 | | 50 | | 750 | |
| 84 | | Item 84 | | 20 | | 30 | | 600 | |
| 85 | | Item 85 | | 10 | | 100 | | 1000 | |
| 86 | | Item 86 | | 5 | | 200 | | 1000 | |
| 87 | | Item 87 | | 15 | | 50 | | 750 | |
| 88 | | Item 88 | | 20 | | 30 | | 600 | |
| 89 | | Item 89 | | 10 | | 100 | | 1000 | |
| 90 | | Item 90 | | 5 | | 200 | | 1000 | |
| 91 | | Item 91 | | 15 | | 50 | | 750 | |
| 92 | | Item 92 | | 20 | | 30 | | 600 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrator, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 should any injury or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | |
| MARGUERITE G. GARDINER | | | | | | | | MONTH DAY YEAR | |
| | | | | | | | | 09 03 83 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Female | | White | | Dec. 13, 1895 | | 87 | | 5:00 am | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Mt Friendship Md. | | USA | | | | PRINCE GEORGES COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CLINTON | | SOUTHERN MARYLAND HOSPITAL CENTER | | Nurse | | Retired | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Charles | | Waldorf | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20621 | |
| 4. FATHER'S NAME | | 5. MOTHER'S MAIDEN NAME | | 6. FATHER'S NAME | | 7. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Aloysius Bowling Gardiner | | Alverta Burch | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | 265-98-8793A | | A. P. Gardiner | | Stuart, Florida 33494 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> | | | | | | | | | |
| 1519 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) <u>Peritonitis</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) <u>Splenic arteriosclerosis</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/27/83</u> to <u>9/3/83</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | |
| M. TALEGHANI, M.D. | | | | | | | | | |
| 4467 Old Branch Ave. Temple Hills, MD 20748 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | |
| 23b. DATE | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Burial Sept 5, 1983 St Ignatius Cem, Chapel Point, Charles, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| W. Clarke Mattingley Leonardtown, Maryland SEP 7 1983 | | | | | | | | | |

MEDICAL CERTIFICATION

7



MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | | | |
|--|--|---|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) THOMAS E GARDNER, SR. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 17 83 | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR July 12, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | 2b. HOUR 4 26PM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Unknown |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Pr 13c. CITY OR TOWN Cheverly 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET ADDRESS 6417 Landover Road 20785 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Gardner | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 229-20-5599 | | 17. INFORMANT ADDRESS Mrs. Evelyn Gardner/wife/same as 13e | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxic Encephalopathy 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Supraventricular | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Alcohol Intoxication | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-17 , 19 83 , to 7-17 , 19 83 , that (I) (we) lost saw the deceased alive on 9-17 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-19-83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CIRO D. Montanez MD | | | | 22e. ADDRESS 3308 Dodge PK Rd - Landover MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-24-83 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover Md. | | |
| 24. FUNERAL DIRECTOR NAME John T. Rhines Co | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |
| 26. ADDRESS 3015 12th St. N.E., D.C. 20017 | | | | | | | | |

09 17 13 4 28PM

GARDNER

E

THOMAS

PRINCE GEORGES

PRINCE GEORGE GENERAL HOSPITAL

CHEMIST



100% COTTON

21 10 80 11 8 10

10 11 11 11 11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25117 | |
|---|--|-----------------------------|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Patricia B. Garner | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9/19/83 MONTH DAY YEAR | | 2b. HOUR 5:00 P M | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Apr 25 1927 | | 6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | 7b. CITIZEN OF WHAT COUNTRY? US | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | |
| 10. CITY OR TOWN OF DEATH Oxon Hill | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2915 Brinkley Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't | |
| 13a. STATE Maryland | | | | | | 13b. CITY Prince Georges | | 13c. CITY OR TOWN Oxon Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harvey Bratton | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Maloney | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 578-40-8628 | | 17. INFORMANT ADDRESS 4016 Woodrow Lane Richard N. Garner, Jr. Bowie, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Carcinoma of lung with metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, PLACE, TYPE, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natal Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | DATE SIGNED 9/23/83 | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> | | | | TITLE (SPECIFY) Deputy Chief M.D. | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St, Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept 26 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Maryland | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home | | | | ADDRESS 16000 Annapolis Road Bowie, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1983 | | 25b. REGISTRAR'S SIGNATURE <i>John E. Carver</i> | |

MEDICAL CERTIFICATION

COM LINES



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 1 AND 2 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25118

REG. NO.

| | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|-----------------------------------|--|---|--|------------------|--|-------------------|--|---------|--|
| 1. FOR STATE REGISTRAR | | 2. DATE KNOWN OF DEATH | | | | | | | | | | 3. DATE OF DEATH | | 4. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2. DATE KNOWN OF DEATH | | 3. DATE OF DEATH | | 4. HOUR | | | |
| GERTRUDE | | A. | | GARNETT | | | | 9 24 83 | | 6 40 | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | 7. DATE PRONOUNCED DEAD | | 8. DATE | | 9. HOUR | | | |
| Female | White | 5 11 16 | | 67 | | TR.S. | | 9 24 83 | | 6 40 | | M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. DATE | | 11. HOUR | | | |
| Washington D.C. | | U.S.A. | | WIDOWED | | DIVORCED | | Prince Geo. County | | 19 83 | | 6 40 | | | |
| 10. CITY OR TOWN OF DEATH. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. STREET ADDRESS | | 14. CITY OR TOWN | | 15. STATE | | | |
| Landover Hills | | 7017 Freeport Street | | Printer | | Gov't | | 20784. | | Hyattsville | | Md. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. ADDRESS | | 19. CITY OR TOWN | | | |
| Unknown | | Unknown | | No | | 577-20-1202 | | Mr. O.P. Blorstad | | 6721 Long Ridge | | Lanham, Md. 20706 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| 4148 IMMEDIATE CAUSE (a) _____ | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | |
| | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | |
| SAR A DARR | | | | M.D. Deputy | | | | 9-25-83 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | 5632 Annapolis Rd Bladensburg MD 20710 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | |
| Burial | | | | 10/5/83 | | | | Cedar Hill Cemetery | | | | | | | |
| 23d. LOCATION | | | | 23e. DATE REC'D BY REGISTRAR | | | | 23f. REGISTRAR'S SIGNATURE | | | | | | | |
| Suitland P.G. Maryland | | | | OCT 6 1983 | | | | John J. Carver | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | |
| Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | | | | | | | | | | | | |

RECEIVED
MEDICAL
OFFICE

Prince Geo. County

January 18, 1918

Prince Geo. County

Prince Geo. County

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 25119 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hugh Gilbert Gauch | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 7, 1983 | | 2b. HOUR 10:20P. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 5, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Botany Professor | | 12b. KIND OF BUSINESS OR INDUSTRY Univ. of Md. | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN College Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Wesley Gauch | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elva Trump | | 13e. STREET ADDRESS Zip Code - 20740 3502 Duke Street | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-38-2537 | | 17. INFORMANT ADDRESS Mrs. Susan Cole Riverdale, Maryland 20737 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Polymyositis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 4 months 4 months | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 11-22-82 , to 09-07-83 , that (I) (we) lost saw the deceased alive on 09-06-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Azher Hussain DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept. 8, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Azher Hussain, M.D. | | | | 22e. ADDRESS 4917 Edgewood Rd. College Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 9, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carish | |

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1. The first of these is the fact that the system is not a simple one, and that the results are not always the same. The second is that the system is not a simple one, and that the results are not always the same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed without delay after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---------------------|--|--|--|-------------------|--|----------|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7a. DATE OF DEATH | | 7b. HOUR | |
| | | GEORGE G. GILLUMS | | Male | | Black | | Aug. 21, 1904 | | 79 YRS. | | 09-01-83 | | 6:30AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| S.C. | | U.S.A. | | | | PRINCE GEORGE'S COUNTY | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| CHEVERLY | | PRINCE GEORGE'S GENERAL HOSPITAL | | Retired | | Railroad | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Md. | | P.G. | | Cap. Hgts. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 511 62nd Pl. | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Elliott | | Gillums | | Maggie | | Fuller | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| No | | 219-30-5595 | | Rose Gillums-Same as # 13 above | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT 4280 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7 31, 19 83 , to 8 31, 19 83 , that (I) (we) last saw the deceased alive on 8 31, 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | |
| <i>[Signature]</i> | | M.D. | | 9/1/83 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | |
| Y.P. SINGH M.D. | | 5632 ANNAPOLIS Rd BLADENSBURG MD. 20710 | | | | | | | | | | | | | |
| 23. BURIAL/CREMATION, REMOVAL (CHECK ONE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | 9-6-83 | | HARMONY MEM. PARK | | HIGHLAND PARK, P.G. Co. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| H.S. Washington + Son | | 4925 N.H.B. Ave | | SEP 9 1983 | | <i>[Signature]</i> | | | | | | | | | |

BP

09-01-82

09-01-82

CHURCH

2.

GEORGE

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

CHEVREY

RECEIVED BY
CORRECTIONAL INSTITUTE
CENTRAL VA. PRISON



RECEIVED BY
CORRECTIONAL INSTITUTE
CENTRAL VA. PRISON

Y. JINCH
N. JINCH

BP_____

DHMH - 17

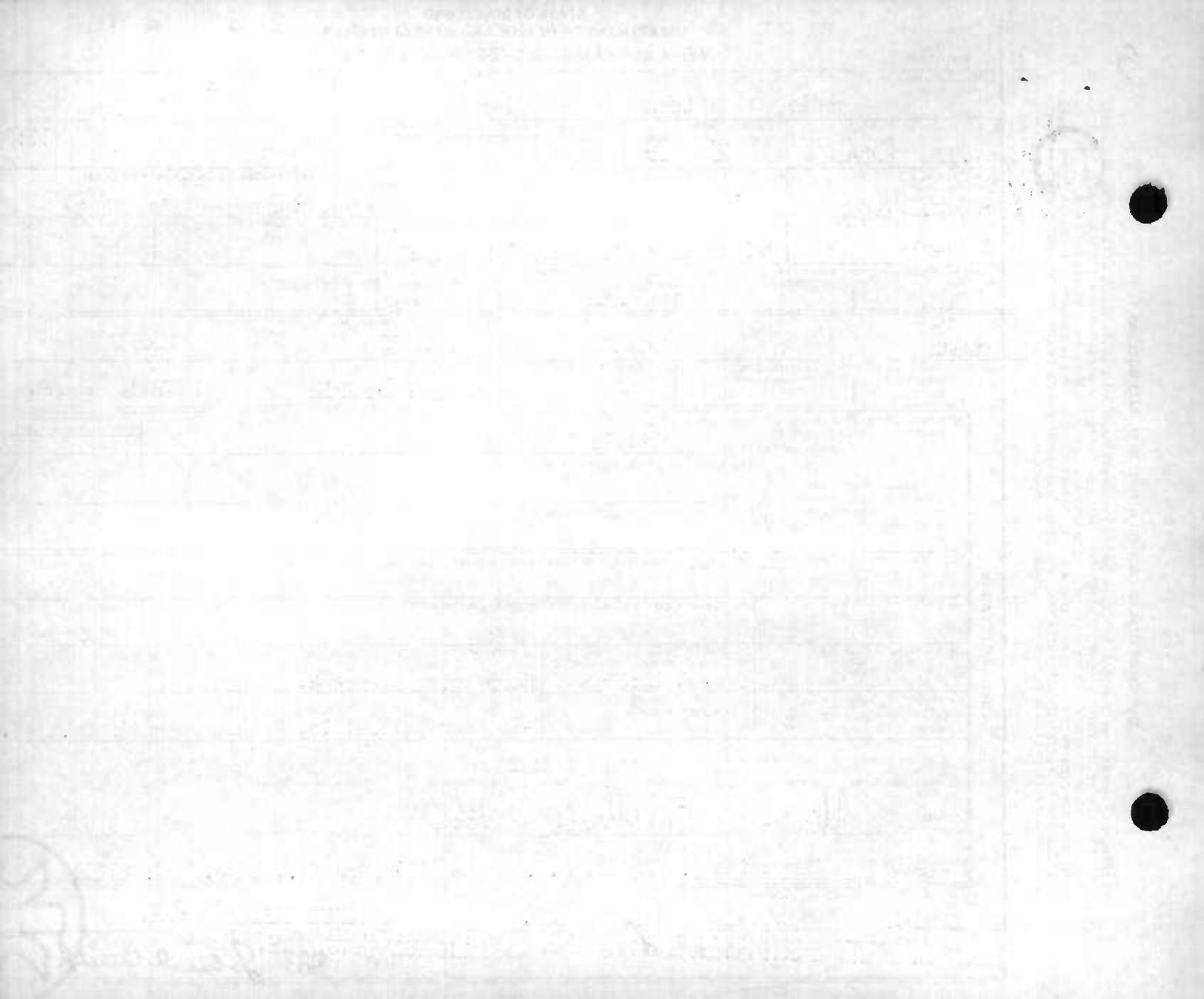
(VR A) 5 ME (5))

20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|---------------------------|--|
| 1- STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 2 5 1 2 1 | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Johnie Leon Glaspie | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED X MONTH DAY YEAR 9/5/83 19 | | 2b. HOUR 11:30 P M | | | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 9 25 39 | | 6. AGE (IN YEARS BIRTHDAY) 43 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 9/5/83 19 | | 7d. HOUR 11:30 P M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WARSAW, N. CAR | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> X | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE MD. | | | | | | | | | | | | 13b. COUNTY CHEVERLY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X | | 13e. STREET ADDRESS 20745 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDGAR GLASPIE | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET MILLER | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT MARGARET GLASPIE | | | | 17. ADDRESS KINSTON, N. CAR. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple Injuries } DUE TO, OR AS A CONSEQUENCE OF (b) } DUE TO, OR AS A CONSEQUENCE OF (c) } | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> X NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/5/83 10:37 PM | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by an auto | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE I-95 Near Beltsville, Prince George's Co., Md. | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> X, Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> X, Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 9/6/83 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 9/9/83 | | | | 23c. NAME OF CEMETERY OR CREMATORY GLASPIE CEM. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE KENASVILLE, N. CAR. | | | | | | | |
| 24. FUNERAL DIRECTOR LEROY O. DYETT & SON FUNERAL HOME, INC. 4600 LIBERTY HTGS. AVE. | | | | 25. DATE RECD. BY REGISTRAR SEP 9 1983 | | | | 25b. REGISTRAR'S SIGNATURE John E. Connel | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 25122 | | | | |
|--|--|---|---|---|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mildred Sorrels Glenn | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 15 83 | | | | | 2b. HOUR 1^A M | | | | |
| 3. SEX Female | | 4. RACE Cau. | | 5. DATE OF BIRTH MONTH DAY YEAR March 17, 1905 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Ft. Washington Md | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fort Washington Rehabilitative Center | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Lakoma Park | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7051 Carroll Ave. 20912 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Alex Sorrels | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta Ola Fox | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-05-8207 | | 17. INFORMANT ADDRESS 10512 Norris Place, Upper Charles H. Glenn, Jr., Marlboro, Md. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 2001 DUE TO, OR AS A CONSEQUENCE OF (b) Cachexia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Lymphocytic Lymphoma | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mms. 2 mms. 4 mons. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic cong. heart failure & senile dementia | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION — 0 — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 0 — | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — 0 — P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — 0 — | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19 83 to 9/14 83 , that (I) (we) <input checked="" type="checkbox"/> lost saw the deceased alive on 9/14 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Richard A. Farson, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 9-15-83 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Farson, M.D. | | 22e. ADDRESS 9401 Indianhead Highway Ft Wash MD 20744 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-17-83 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardnes Waldorf, Charles, Md. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Staldorf, Md | | ADDRESS SEP 19 1983 | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | | | |

BP



Winston Morris

Female

Virginia

11th Street

771 1st Ave. N.E.

Robert Max Morris

1st St. N.E. 771 1st Ave. N.E.

1st St. N.E. 771 1st Ave. N.E.

1st St. N.E. 771 1st Ave. N.E.

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1st St. N.E. 771 1st Ave. N.E.

1st St. N.E. 771 1st Ave. N.E.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

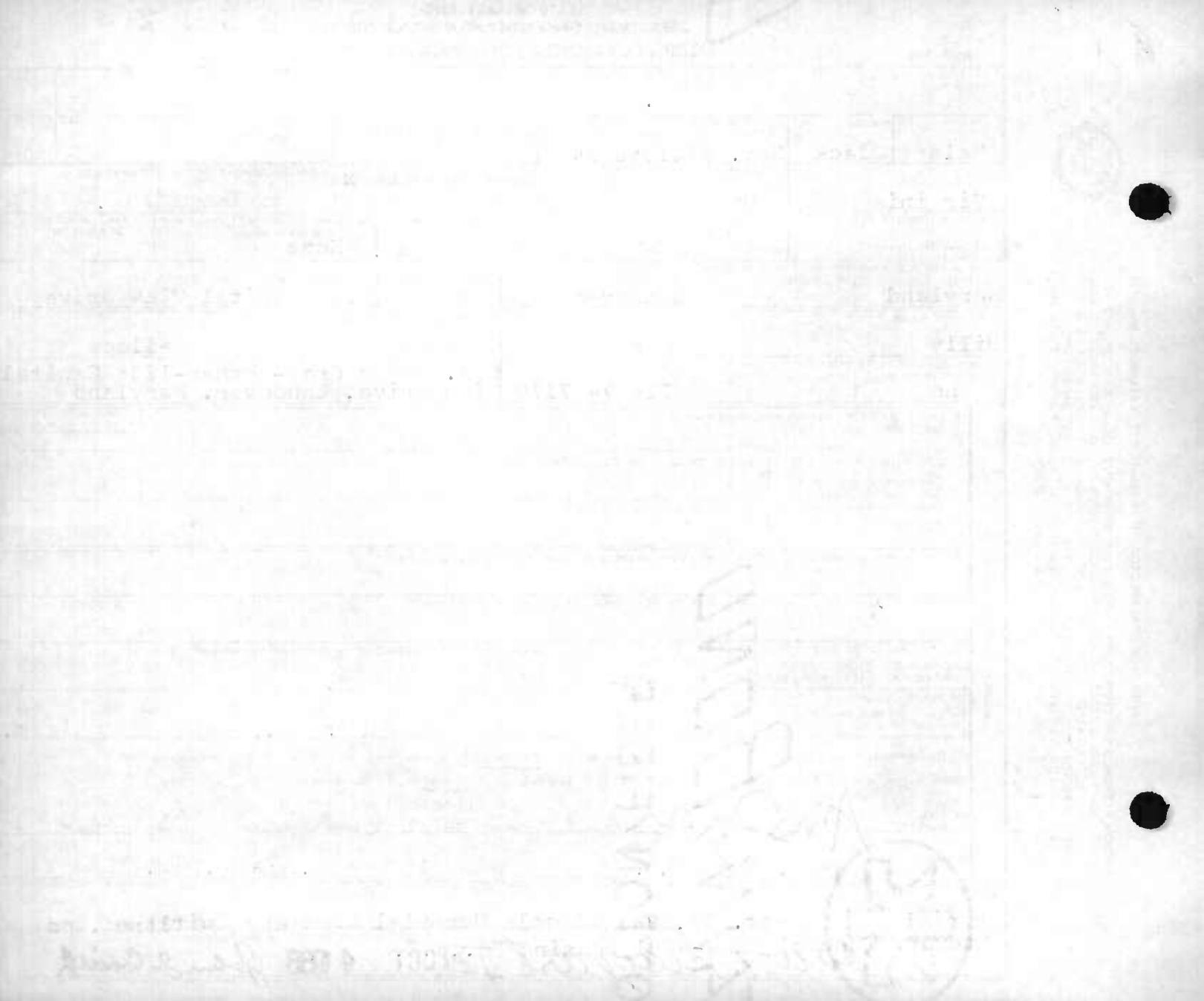
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25123

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|------------------|---|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) THOMAS B. GRAY | | | 7a. DATE KNOWN OF DEATH MONTH DAY YEAR 9 21 1983 | | | 7b. HOUR M M | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 27, 1958 | 6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 21 1983 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD. | | |
| 10. CITY OR TOWN OF DEATH Landover | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) parking lot-7822 George Palmer Hwy. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | 13b. COUNTY Landover | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 20784 1236 Capital View Drive | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Billy Gary | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joyce Wallace | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 74 7179 | | 17. INFORMANT Mrs. Joyce Gray-mother-1236 Capital View Drive, Landover, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9650 Gunshot wounds of head and chest (handgun) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 10:30M. 9-21- 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject was shot. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7822 George Palmer Hwy., Prince George's Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon, M.D. | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 9-22-83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept. 26, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md | |
| 24. FUNERAL DIRECTOR Stewart | | | 24b. DATE REC'D. BY REGISTRAR OCT 4 1983 | | 24c. REGISTRAR'S SIGNATURE John J. Stewart | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 2 5 1 2 4

| | | | |
|---|---|---|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST Emanuel J Green | | MONTH DAY YEAR HOUR 9/5/83 5 53 3:30 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| M | W | MONTH DAY YEAR 12 1 19 | 6 3 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| PA | US | | Prince George's County MD |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| River Dale | Leland Memorial Hospital | LAB TECH GULF OIL CO | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? |
| PA | DEL | LLIFTON HEIGHTS | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| Manuel Green | Margaret McFadden | YES | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | |
| 165-44-9374 | MARGARET GREEN | 5241 FAIR HAVEN RD, HEIGHTS CLIFTON PA | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) central emboli, recurrent | | 1 day | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Disease | | 2 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 110 Diabetes mellitus, Decubitus ulcers | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| N/A | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/5/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | 22b. SIGNATURE Paul A DeVore MD | | |
| 22c. DATE SIGNED 9/5/83 | | 22d. ADDRESS 6525 BELCREST ROAD HYATTSVILLE MD 20382 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| BURIAL | 9/9/83 | S.S. PETER & PAUL | SPRINGFIELD DEL. PA |
| 24. FUNERAL DIRECTOR NAME | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE | |
| Richard E. Woodie | SEP 16 1983 | John J. Canish | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|-------------------------|---|---|---|--|--|--|--|------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HELEN L. GREENWALD | | | | | | | | | | 2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 9 DAY 9 YEAR 83 | |
| 3. SEX female | 4. RACE white | 5. DATE OF BIRTH MONTH Oct. DAY 1 YEAR 1910 | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | 7c. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George | 10. DATE PRONOUNCED DEAD MONTH 9 DAY 9 YEAR 83 | 11. HOUR 7 p | 12. HOUR M | |
| 10. CITY OR TOWN OF DEATH Riverdale | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Code Clerk (ret) | | 12b. KIND OF BUSINESS OR INDUSTRY State Dept | |
| 13a. STATE Maryland | | | | 13b. COUNTY Pr George | 13c. CITY OR TOWN Blvd. Hts. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 3912 Ellis Street S.E. | | | | |
| 14. FATHER'S NAME FIRST Elmer MIDDLE Reese LAST Cleona | | | | 15. MOTHER'S MAIDEN NAME FIRST Cleona MIDDLE Bowden LAST Bowden | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | |
| 17. SOCIAL SECURITY NO. 578-22-7742 | | | | 18. INFORMANT Irene Gignac | | | | 19. ADDRESS 4410 Sheridan St. Hyattsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Hypertensive arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | 22b. DATE REC'D. BY REGISTRAR SEP 16 1983 | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 9/10/1983 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn ct., Camp Springs MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 13Sept83 | | | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood | | | |
| 23d. LOCATION CITY OR TOWN PG | | | | 23e. COUNTY Md | | | | 23f. STATE | | | |
| 24. FUNERAL HOME NAME Robert E. Wilhelm | | | | ADDRESS Suitland, Md. | | | | 25. REGISTRAR'S SIGNATURE <i>John J. Casella</i> | | | |

937

United States of America

Department of the Interior

Geological Survey

Washington

100

100

100

100

James H. [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25126 | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gerry B. Gregory | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 18 83 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 7 27 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD. | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN CITY OR TOWN OF DEATH) CARROLL MANOR NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't | |
| 13a. STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Chevy Chase | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE Yn Known | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Amelia Unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | |
| 16b. SOCIAL SECURITY NO. 110-09-7735 | | 17. INFORMANT Peter E. A. Gregory 1818 Belmont Rd. NW Washington, D.C. 20009 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4049 ACUTE CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTS/CAR RENOVAS DIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CEREBRAL ISCHEMIA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/16/83 to 9/18/83, that (I) (we) lost saw the deceased alive on 9/16/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Frederick W. Schneider MD | | DEGREE MD | | 22c. DATE SIGNED 9/18/83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK W. SCHNEIDER | |
| 22e. ADDRESS 201-8 STONE DC | | 23a. BURIAL, CREMATION, REMOVAL Burial | | | | | |
| 23b. DATE 9-20-83 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont. MD | | | |
| 24. FUNERAL DIRECTOR NAME Jos. Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., DC 20016 | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1983 | | | | | |



no
110-62-755
Peter S. A. Gregory
Washington, D.C. 20002
Uniform
7102
x
20015
y the villa
various other items
one

110-62-755
Peter S. A. Gregory
Washington, D.C. 20002
Uniform
7102
x
20015
y the villa
various other items
one

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Grimes Helen Helen Grimes | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/15/83 | | | 2b. HOUR 3:50 PM | | | |
| 3. SEX male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 4-21-1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Convalescent Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hospital Admin. | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2600 Queens Chapel Rd. #308 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unk. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty E. Powell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229-14-7269 | | 17. INFORMANT ADDRESS Joanna A. Lane 2600 Queens Chapel Rd. #308 Hyattsville, Md. 20782 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Embolic infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic heart disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Anemia | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-26 , 19 82 , to 9/15 , 19 83 , that (I) (we) last saw the deceased alive on 8/14 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE M. Nemati | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 9/15/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Nemati | | | 22e. ADDRESS 3611 Branch Ave Temple Hills Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 9/15/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Med. School | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Columbia Mortuary Services, Inc. 225 Missouri Ave. NW Washington, D.C. 20011 | | | | | 25. DATE REC'D. BY REGISTRAR SEP 21 1983 | | | | |
| | | | | | REGISTRAR'S SIGNATURE John J. [Signature] | | | | |

BP

Helen Holmes

Hospital Admin. Hattiesburg

20792

Unk.

Betty

B.

Hawaii

Joanna A. Jones
2600 Orange Grove Rd.
Baltimore, Md. 20702

No

xx

Removal
Columbia County Services, Inc.
225 Maryland Ave. NW Washington, D.C. 20011
9/15/93 Geo. Wash. Sch. School
Washington, D.C.
9/15/93 2100 2nd St. S.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3044

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LYLE R HAINES | | | | 2. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 2, 1983 | | | |
| 3. SEX MALE | | | | 4. RACE WHITE | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 10, 1932 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 51 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA | | | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD | | | |
| 10. CITY OR TOWN OF DEATH ANDREWS AFB | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | 13b. COUNTY PRINCE GEORGE | | | |
| 13c. CITY OR TOWN UPPER MARLBORO | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LYLE E HAINES | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED E DAVIS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1956-1970 | | | |
| 17. INFORMANT ADDRESS ROSEMARIE HAINES 10101 QUINCE APPLE CT | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1619 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (c) with metastasis to lungs. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 min. 10 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE ANGUS MARSHALL | | | | DEGREE PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 02 SEP 83 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) Angus Marshall | | | | 23b. ADDRESS 20331 MALCOLM GROW USAF MED CTR ANDREWS AFB, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE September 6, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia | |
| 24. FUNERAL DIRECTOR Lee Funeral Home, Inc. NAME ADDRESS Old Alexander Ferry Road, Clinton, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 6 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE John D. Conner | | | | | | | |



Handwritten text, likely a signature or name, appearing upside down.

Handwritten mark, possibly a checkmark or the letter 'X'.

Handwritten signature or name, appearing upside down.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ralph E. Haller | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-3-83 | | | 2b. HOUR 11:40^{AM} | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 6, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 99999 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Convalescent Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | | 12b. KIND OF BUSINESS OR INDUSTRY self employee | | |
| 13a. STATE Virginia | | | | | 13b. CITY OR TOWN Dale City | | 13c. STREET ADDRESS 14747 Barksdale | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Eli Haller | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeanette Holmes | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 579-09-0848 | | 17. INFORMANT Edward Haller / Son | | | | ADDRESS Same as #13 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Congestive Heart Failure**

4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

Chronic Obstructive Pulmonary Disease

DUE TO, OR AS A CONSEQUENCE OF

Arteriosclerotic Heart Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Carcinoma of Lung

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/4 , 19 83 , to 9/3 , 19 83 , that (I) (we) last saw the deceased alive on 9/2 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Reza Mostaan | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/3/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Reza Mostaan | | | | 22e. ADDRESS 4235 28th Ave. Marlow HTS, MD 20748 | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 4Sept-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland PG Md | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm | | | | ADDRESS Suitland, Md | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | |
| 25b. REGISTRAR'S SIGNATURE Chas. J. Connel | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

CHIEF

30% COLLO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES EDWARD HAMILTON SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 26 83 | | | 2b. HOUR 4:40P.M. | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 27, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER | | 12b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY PR. GEO'S. | | 13c. CITY OR TOWN UPPER MARL | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 6300 OSBORNE ROAD SOUTH | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SYLVESTER HAMILTON | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HENRIETTA LEWIS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212 20 1143 | | 17. INFORMANT ADDRESS CHARLES HAMILTON, JR. SAME AS 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accidents 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetic Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION 9/29/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetic Mellitus | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 18 Aug 1983 to 26 Sept 1983 , that (I) (we) last saw the deceased alive on 25 Sept 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R.B. SASSER MD | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/25/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. B. SASSER | | | | 22e. ADDRESS 5506 GREEN LANDING ROAD, UPPER MARLBORO, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/29/83 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton PG. MD. | | | |
| 24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | 25b. REGISTRAR'S SIGNATURE James G. Carver | | | |
| 4339 HUNT PLACE, N.E. | | | | | | | | | |

BP

CHARLES WILTON

PRINCE GEORGE

PRINCE GEORGE GENERAL HOSPITAL

C. EVERLY

100% COTTON
CHIEF



ROLLINS FUNERAL HOME, INC.
4339 HUNT PLACE, N.E.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) June Alene HARRIS | | | 2a. DATE OF DEATH MONTH DAY YEAR September 6, 1983 | | 2b. HOUR 5:50am |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 30, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH LANHAM | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL OF P.G. CO | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nanny | | 12b. KIND OF BUSINESS OR INDUSTRY Child Care |
| 13a. STATE Maryland | | | 13b. COUNTY P.G. | 13c. CITY OR TOWN Greenbelt | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hugh C. Andree | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Kappel | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 578-22-9588 | | 17. INFORMANT ADDRESS Address Same as No# 13e. Miss Kathy Harris | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE LEUKEMIA</u> 2080 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>2080</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> , 19 <u>83</u> , to <u>9/6</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/6</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Rog B. Ingham</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept. 6, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger B. Ingham, M.D. | | 22e. ADDRESS 5701 - 85th Avenue, New Carrollton, Md. | | | |

MEDICAL CERTIFICATION

| | | | |
|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Sept. 9, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland |
| 24. FUNERAL DIRECTOR NAME <u>L. Joseph Louis</u> | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1983 | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25132

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) MARY PEARL HAYES | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 10, 1983 | | 2b. HOUR P M 1:19 P M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR April 30, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | |
| 10. CITY OR TOWN OF DEATH Lanham | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of P.G. County | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 13a. STATE Maryland | | | 13b. COUNTY Pr. George's | 13c. CITY OR TOWN Clinton | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alvin L. Saunders | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Corenna B. Williamson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS 582 Haystack Landing Road John Hayes Newport News, Virginia 23602 | |

| | | | | | |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, Kidney shot down 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Hypocalcemia and electrolyte imbalance DUE TO, OR AS A CONSEQUENCE OF (c) Bone metastases, den. Co of RT + left breast | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Decrease in immune response due to Chemio therapy | | | | | |
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of both breast | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31/83 , 19____, to 9/10/83 , 19____, that (I) (we) lost saw the deceased alive on 11/8 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Elie A. Sayan | | DEGREE M.D. | | 22c. DATE SIGNED 9/14/83 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) ELIE A. SAYAN. M.D. | | 22f. ADDRESS 5803 Landover Rd Chevy Chase MD | | | |

| | | | |
|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE September 13, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Pr. George's, MD |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1983 | 25b. REGISTRAR'S SIGNATURE [Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7



MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

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9. [Illegible]

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11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

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97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25133 | | | |
|---|--|-------------------------|--|--|--|---|--|---|--------------------------|---|--|--------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH M. HEBRON | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 4 1983 | | 2b. HOUR a. m. | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Aug 8, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED MONTH DAY YEAR Dec 9 4 1983 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH Temple Hills | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5505 Chesterfield Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Silk Finisher | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Prince Georges | | 13c. CITY OR TOWN Temple Hills | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5505 Chesterfield Drive | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wilbur Lothrop | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Campbell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Not Stated | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Not Stated | | 17. INFORMANT ADDRESS 21 Franklin St., N.E. Constance Fantroy, Daughter, Washington, DC | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 9/4/1983 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9 Sep 83 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR NAME W. Ernest Jarvis Co., Inc., | | | | ADDRESS 1432 10th St., N. W. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Lohr | | | |

W. Ernest Jarvis Co., Inc., Washington, D. C.
 9 Sep 83
 Mount Olivet Cemetery
 Washington, D. C.

Charles Jarvis

Not stated

Not stated

Constance Fenroy, daughter, Washington, D. C.
 21 Franklin St., W. T.

William Lathrop

Wilfred Campbell

Maryland Prince Georges Temple Hills x 2505 Chestnutfield Drive

Temple Hills

Washington, D. C. U. S. A.

X Prince Georges

Aug 8, 1911 69

M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one of the following:

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 25134 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude D. Hemmerich | | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 22, 1983 | | 2b. HOUR 8:45 A.M. | |
| 3. SEX female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 7 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | |
| 10. CITY OR TOWN OF DEATH Adelphi | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8520 Adelphi Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Office U.S. Patent | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 20783 | | | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN Adelphi | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Duehring | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Manglitz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-40-7476 | | 17. INFORMANT ADDRESS Kathleen Manglitz. Same as item 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, dehydration, Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chest's Diseases and Rheumatoid Arthritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5559</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> , 19 <u>83</u> , to <u>9-22-83</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>8-14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE For Dr. Connally, J. Thomas Connally M.D. | | | | 22c. DATE SIGNED 9-22-83 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. M. Connally J. N. Thomas Connally | |
| 22e. ADDRESS 3301 New Mexico Ave N.W. 20016 | | | | 22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/26/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland. | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Washington, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE John J. Connally | | | | | | | |

RECEIVED
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.

Mr. Tolson
Mr. E. A. Tamm
Mr. Clegg
Mr. Glavin
Mr. Ladd
Mr. Nichols
Mr. Rosen
Mr. Tracy
Mr. Carson
Mr. Egan
Mr. Gurnea
Mr. Hendon
Mr. Pennington
Mr. Quinn
Mr. Nease
Miss Gandy

U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535
JUL 28 1953
RECEIVED
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25135

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | |
|---|---------|--|--|---|--|--------------------------------------|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH DAY YEAR 9 10 83 | | 2b. HOUR 19 | |
| ROBERTA | | | | | | HILL | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | Negro | Dec. 23, 1923 | | 59 | | | | | | 9 10 83 | | 11/20 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| N.C. | | USA | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Capitol Heights | | 708 Nova Avenue | | Domestic | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | | |
| North Carolina | | | | Thomasville | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 319 Church Street | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST | | | | MIDDLE | | | | LAST | | | | | |
| unknown | | | | Emma Rickard | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | |
| no | | | | 251208212 | | | | 708 Nova Avenue | | | | | |
| | | | | Mrs. Elizabeth Jennings-sister | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) M.D. Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 9/10/1983 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| Augusto P. Rodriguez, M.D. | | | | 5009 Rayburn Ct., Temple Hills, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | | | Sept. 16, 1983 | | | | City Cemetery | | | | Thomasville, N.C. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Stewart | | | | SEP 22 1983 | | | | John J. Conrad | | | | | |

Dec. 11, 1933

W.C.

Editorial

W.C.

W.C.

W.C.

W.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JAMES PATRICK HINKLE | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 20, 1983 | | 2b. HOUR 11:35pm |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 19 1929 | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH LANHAM | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO. | | 12a. USUAL OCCUPATION (MOST OF WORKING LIFE) Furniture Store | | 12b. KIND OF BUSINESS OR INDUSTRY Department Store |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY P.G. | 13c. CITY OR TOWN Seabrook | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 9121 Lanham Severn Road |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hametd Hinkle | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Holoway | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579-36-0477 | | 17. INFORMANT ADDRESS Catherine F. Hinkle Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-31</u> , 19 <u>83</u> , to <u>9-20</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9-20</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Sankar Nayar</u> | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.M. NAYAR MD | | 22e. ADDRESS 3717-38 th AVE BRENTWOOD MD 20722 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-24-1983 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C. |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons P.A. | | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | |
| ADDRESS Hyattsville, Md. | | | REGISTRAR'S SIGNATURE <u>John G. Smith</u> | | |

BP _____

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------|---|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Joey Lee Hodge | | | | | | 2a. DATE KNOWN OF DEATH MONTH 9 DAY 11 YEAR 1983 | | 2b. HOUR M | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH January DAY 13 YEAR 1964 | | 6. AGE (IN YEARS) LAST BIRTHDAY 19 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | | 2c. DATE PRONOUNCED DEAD MONTH 9 DAY 11 YEAR 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, Md. | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder | | 12b. KIND OF BUSINESS OR INDUSTRY Pvt. | | |
| 13a. STATE Maryland | | | | | | 13b. CITY OR TOWN Charles | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3508 Lisa Lane | |
| 14. FATHER'S NAME FIRST Charles R. MIDDLE Hodge LAST Hodge | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Jenith A. MIDDLE Ballenger LAST Ballenger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. ***** | | 17. INFORMANT ADDRESS Mr. Charles R. Hodge, same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8150 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 xxx 9 11 19 83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/fixed object impact | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | 21f. LOCATION STREET Rt. 301 CITY OR TOWN Brandywine COUNTY P.G. STATE Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> | | | | TITLE (SPECIFY) Deputy Chief | | | | DATE SIGNED 9/11/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn ST. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 9/14/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat.Cem. | | | 23d. LOCATION CITY OR TOWN Arlington, Virginia COUNTY VA STATE VA | | |
| 24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME, 6633 Old Alex- ander Ferry Rd., Clinton, Maryland 20735 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1983 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i> | | | |

M

REBIL 1010

25

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25138 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Preston Gehr Horst | | | | | | | | | | 2a. DATE KNOWN OF DEATH 9 19 1983 | |
| 3. SEX Male 4. RACE White 5. DATE OF BIRTH March 8 1912 6. AGE (IN YEARS) 71 7. YRS. 71 8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2b. DATE OF DEATH 9 19 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 9 19 1983 | |
| 10. CITY OR TOWN OF DEATH Hyattsville 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5706 40th Place 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Contractor 12b. KIND OF BUSINESS OR INDUSTRY Carpenter | | | | | | | | | | 2d. HOUR 2:35P | |
| 13a. STATE Maryland 13b. CITY OR TOWN Prince Georges 13c. CITY OR TOWN Hyattsville 13d. INSIDE CITY LIMITS? YES 13e. STREET ADDRESS 5706 40th Place Zip 20781 | | | | | | | | | | | |
| 14. FATHER'S NAME Abram Horst 15. MOTHER'S MAIDEN NAME Gertrude Gehr | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes 16b. SOCIAL SECURITY NO. 214-14-6345 17. INFORMANT Margaret R. Horst ADDRESS Same as 13e (Wife) | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Gunshot wound of neck Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY 9 19 1983 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | |
| 21f. LOCATION 5706 40th Place CITY OR TOWN Hyattsville COUNTY P.G. STATE MD. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 9/20/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 9-23-1983 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery 23d. LOCATION Brentwood COUNTY P. G. STATE MD. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis Gasch's Sons, P.A. ADDRESS Hyattsville, Md. 25a. DATE REC'D. BY REGISTRAR SEP 23 1983 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | | | | | | | |

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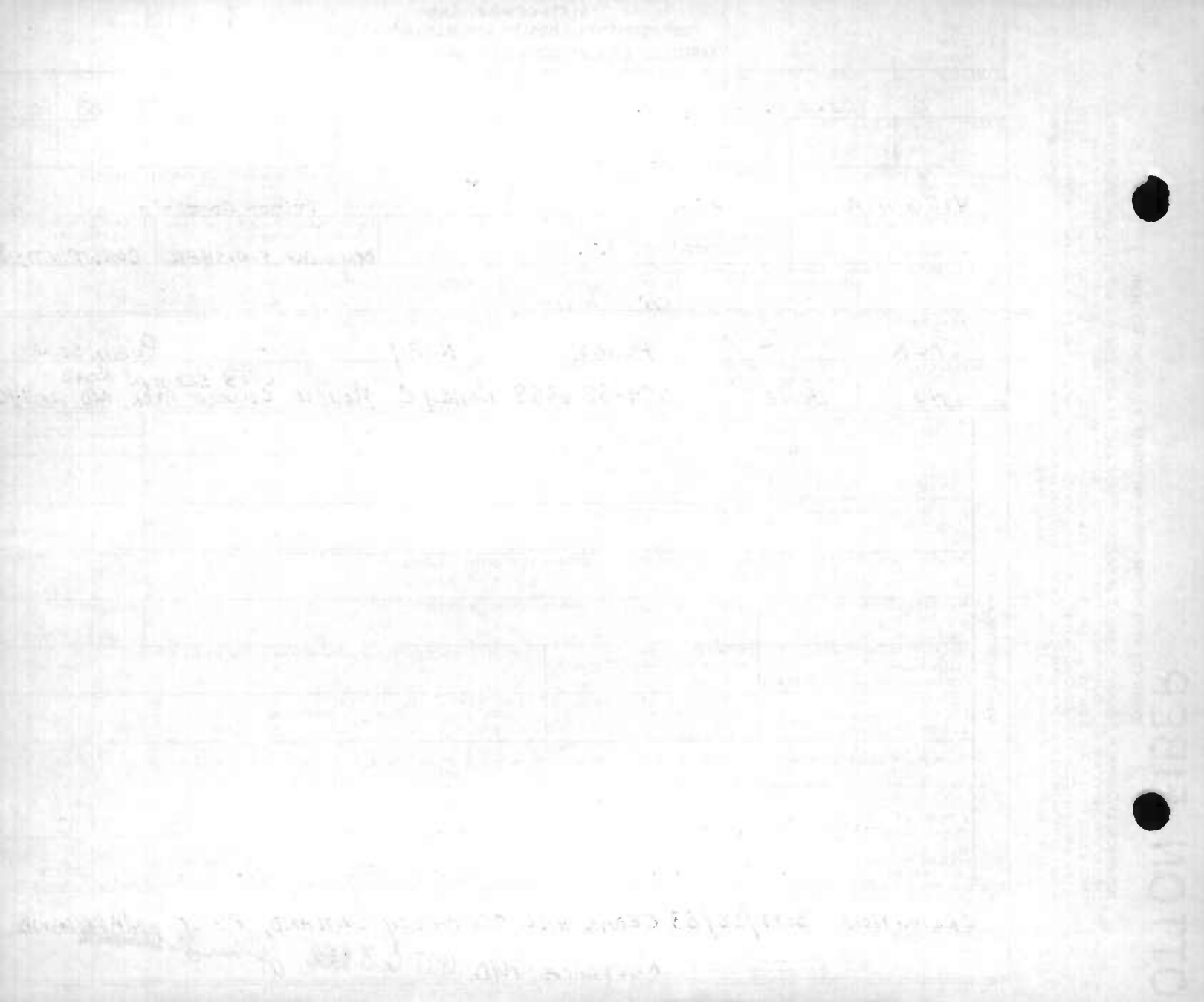
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | |
|--|---------------------|--|--|---|---|---|--|--|------------------------|--|--|------------------------|
| 1- STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James K. Hough, Sr. | | | | | | | | | | ESTIMATED MONTH DAY YEAR 9 27 1983 | | 2b. HOUR 7am |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 9 17 31 52 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 52 | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 27 1983 | | 2d. HOUR 7am | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' of P.G. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRY WALL FINISHER | | 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | | | |
| 13a. STATE MD | | 13b. COUNTY PG | | 13c. CITY OR TOWN College Park | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6005 Berwyn Road 20740 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JACK - HOUGH | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUBY - ROBINSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 579-38-6358 | | 17. INFORMANT Nancy C. Hough | | | ADDRESS 6005 BERWYN ROAD COLLEGE PARK, MD. 20740 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of stomach 1519 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS CONTRIBUTING <input type="checkbox"/> OR CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Said A. Dae | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 9/28/83 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Said A. Dae, M.D. | | | | ADDRESS 5632 Annapolis Rd. #10, Bladensburg Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE SEPT/28/83 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITSAND, PG. CO. MARYLAND | | | | |
| 24. FUNERAL DIRECTOR NAME Chambers Funeral Home | | | | ADDRESS RIVERDALE, MD. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Marjorie C. Huang <i>MARJORIE C. HUANG</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/1/83 <i>9/1/83</i> | | | 2b. HOUR 11 AM. <i>11 AM.</i> | | | |
| 3. SEX Female | | 4. RACE Oriental | | 5. DATE OF BIRTH MONTH DAY YEAR Mar. 25, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 8 25 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Adelphi Manor | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Pr. Georges | | | 13b. CITY OR TOWN Hyattsville | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 4002 Underwood Street, 20782 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown Chen | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A | | | 16b. SOCIAL SECURITY NO. 214-60-3873 | | 17. INFORMANT ADDRESS Rosalind Huang-daughter-(same as 13e) | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable metastatic Carcinoma 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right Pulmonary mass DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months | |
|---|--|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/83 to 9/1/83 , that (I) (we) lost saw the deceased alive on 9/1/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Don H. Yablonowitz | | | | DEGREE M.D. | | 22c. DATE SIGNED 9/1/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Don H. Yablonowitz | | | | 22e. ADDRESS 10300 Greenbelt Rd, Seabrook, Md 20706 | | | |

| | | | | | | | |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-5-1983 | | 23c. NAME OF CEMETERY OR CREMATORY George Washington | | 23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Prince Georges Md. | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | | | 11800 N.H. Ave., Srl. Spr. Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 2 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Address: 11800 N.E. Ave.
City: Seattle, Wash.
State: WA
Zip: 98148
Name: Prince George's No.

WA 014-60-3873
Residing Young-bachelor (name in 1960)

Married
4002 Underwood Street, 20712

Married
Mar. 22, 1964

Married
G. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 25141 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FREDERICK S. HUTCHINSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-14-83 | | 2b. HOUR 1:17 P.M. | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 02 20 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | |
| 7a. BIRTHPLACE (COUNTRY) Oakland Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH Forestville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Representative | | 12b. KIND OF BUSINESS OR INDUSTRY Morrell Meat | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STREET ADDRESS 7006 Mason Street 20747 | | | |
| 13a. STATE Maryland | | 13b. COUNTY PG | | 13c. CITY OR TOWN Dist. Hts. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Willoughby F. Hutchinson | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Clara Marks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. 212-03-7583 | | 17. INFORMANT ADDRESS Mary E. Hutchinson Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:15 9 83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (CITY OR TOWN, COUNTY, STATE) 85 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-15 , 19 83 , to 9-11 , 19 85 , that (I) (we) last saw the deceased alive on 9-11 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) find the body after death. | | | | 22c. DATE SIGNED 9/11/83 | | | |
| 22b. SIGNATURE G. Edrecombe md | | | | 22e. ADDRESS 6188 Oak Hill, Md 20745 | | 22f. DATE REC'D. BY REGISTRAR SEP 22 1983 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-14-83 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cem. | | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Cheltenham Md. | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home | | | | 25. REGISTRAR'S SIGNATURE John J. Connelley | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|-------------|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Susan Iglehart | | | | MONTH DAY YEAR 9 16 82 | | 7b. HOURS MIN 6 45 AM | |
| 3 SEX ♀ | 4 RACE W | 5 DATE OF BIRTH MONTH DAY YEAR January 10, 1994 | | 6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD | | | |
| 10 CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. STREET ADDRESS | | | |
| 13a. STATE Md | | 13c. CITY OR TOWN College Park | | 13d. STREET ADDRESS 5-489 Sunnyside Ave | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles Baldwin | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Croston | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 214-54-9864 | | 17 INFORMANT ADDRESS Brenda Montfeld - same | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CEREBRAL EDEMA</u> 4331 DUE TO, OR AS A CONSEQUENCE OF (b) <u>OCCLUSION OF LEFT INTERNAL CAROTID ARTERY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>NATURAL CAUSES</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 HRS. 5 DAYS | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>HYPOTENSION, ATRIAL FIBRILLATION, BRADYCARDIA</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>8/15/83</u> to <u>9/16/83</u> , that (1) (we) lost saw the deceased alive on above (1) (we) (did) (did not) view the body after death. (and that (my) (our) opinion of death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE <u>Philip C. [Signature]</u> | | 22c. ADDRESS 7500 GREENWAY CTR DR GREENSBORO MD 27220 | | 22d. DATE SIGNED 9/16/83 | | 22e. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Burial | | 23b. DATE 9/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY St Marks Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Highland Md | |
| 24 FUNERAL DIRECTOR NAME Donaldson Funeral Home Laurel, Md | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1983 | | 25b. REGISTRAR'S SIGNATURE John J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | | | | |
|--|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ARVINE C. Jackson, Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR 09 04 83 12 06 PM | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Jan 13 1945 | | 6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS. | | 7b. HOUR 12 06 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH Cheverly, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Dept. of Justice | |
| 13a. STATE Maryland | | 13b. COUNTY Adelphi | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Apt. 202, 2004 Erie St., Adelphi, Md. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arvine C. Jackson Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Peyton | | | | 20783 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 579 58 4625 | | 17. INFORMANT Mabel L. Jackson | | ADDRESS 2004 Erie St, Adelphia, Md. Apt. 202 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock with Ventricular arrhythmia 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Massive myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Diffuse Coronary Artery Disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Apr. 15 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ① Hypertension ② Hematemesis ③ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 3rd , 19 83 , to Sept 4th , 19 83 , that (I) (we) lost saw the deceased alive on 11:25 AM , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ravinder K. Rustagi MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 9/04/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAVINDER K. RUSTAGI, MD | | | | 22e. ADDRESS 5632 ANAPOLIS ROAD SUITE 7 BLADENSBURG, MD 20710 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/10/83 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland | | | |
| 24. FUNERAL DIRECTOR Nutter and Sons Funeral Home, Inc. | | 2501 Gwynns Falls Pkwy Balto., Md. 20 | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|---|--|---|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| JOHN | | 09-24-83 | | | | 2:30PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | Black | 9 4 1895 | 88 | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| West Virginia | USA | | PRINCE GEORGE'S COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CHEVERLY | P.G. NURSING CARE CENTRE | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13d. INSIDE CITY LIMITS? | | 13. STREET ADDRESS | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Rt 1 Box 241, 20613 | | | |
| Maryland Charles Brandywine | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| Unknown | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 577-22-7489 | | Sarah Jamerson | | S/A | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| 0389 IMMEDIATE CAUSE (a) | | Congestive Heart Failure + | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | Septicemia | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | CVA, Hypertension, P.m., Decub. Ulcer. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| AT WORK AT WORK | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Joseph Richichi | | MD | | 9/25/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Joseph Richichi | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 9/29/83 | | Ch. of God House Prayer | | Brandywine P.G. Md | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Name | | OCT 5 1983 | | John J. Canish | | | |
| Marcell Adam | | Aguasco Md 20607 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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PRINCE GEORGE'S COUNTY

P. D. HURST, CARE CENTER

OVERLY

Corporate Trust
Spartan

for CUB, Hyattsville, D.C., Dec 1977

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10/20/77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ISAAC JAMES | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 22 1983 | | 2b. HOUR 11:15 M | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR FEB 9 29 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GUYANA S. A | | 7b. CITIZEN OF WHAT COUNTRY? SOUTH AMERICA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH ANDREWS AFB | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STORE CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY DART DRUG | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY P.G | | 13c. CITY OR TOWN FORESTVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3241 WALTERS LANE #102 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST KAM JAMES | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORIS FONTANELLE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 102-50-9876 | | 17. INFORMANT ADDRESS DORIS ELDER 170 LINCOLN RD BROOKLYN NY | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 22 Sep 19 83 , to 22 Sep 19 83 , that (we) last saw the deceased alive on 22 Sep 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Kurt Harding</i> | | | | DEGREE DO ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 23 Sep 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KURT HARDING, M.D. | | | | 22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/26/83 | | 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home Oxon Hill, Md. | | | | ADDRESS 6160 Oxon Hill Rd | | 25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) SEP 28 1983 <i>John J. Carver</i> | | | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

X

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

CHIEF

100% COTTON FIBER



UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

PLANT

WASHINGTON, D. C.

George Washington University, Washington, D. C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES P JOHNSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-27-83 | | | 2b. HOUR 9:59AM | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 27, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Capitol Hgts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Johnson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie C. Green | | | 13e. STREET ADDRESS 902 Nyanga Avenue, 20743 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 718 14 9418 | | 17. INFORMANT ADDRESS Mrs. Daisy R. Johnson-wife-902 Nyanga Avenue, Capitol Heights, Maryland | | | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE (c) ATHEROSCLEROTIC HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) acute Myocardial Infarction | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/27/83 , 19 83 , to 9/27 , 19 83 , that (I) (we) last saw the deceased alive on 9/27/83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Vicente Laboy | | 22c. DATE SIGNED 9/27/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vicente Laboy, MD | | 22e. ADDRESS Prince George's General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 1, 1983 | |
| 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Park Landover, Maryland | |
| 24. FUNERAL DIRECTOR Stewart Funeral Home | | 25a. DATE REC'D. BY REGISTRAR Oct. 4, 1983 | |
| 25b. REGISTRAR'S SIGNATURE John J. Connel | | 25c. REGISTRAR'S SIGNATURE John J. Connel | |

MAR 27 1952

07-27-52

JOHNSON

P

CHARLES

PRINCE GEORGES

PRINCE GEORGES GENERAL HOSPITAL

CIVILIAN

PRINCE GEORGES

100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25147 | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES H. JOHNSON | | | | 2b. DATE OF DEATH MONTH DAY YEAR 09-21-83 | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 4 6 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NURSING CARE CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN KENT LAND | | 13e. STREET ADDRESS 2406 Fire House Rd. 20785 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JOHNSON | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE HARRIS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 216-16-9321 | | 17. INFORMANT ADDRESS ELIZA JOHNSON 2406 Fire House Rd. 20785 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ALVEOLAR RIDGE CARCINOMA 10-15 MTHS. 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): MULTIPLE STROKES | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 83 , to 9/20 , 19 83 , that (I) (we) last saw the deceased alive on 9/20 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>James H. Johnson</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/21/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 9-24-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Church Ceme. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lothian A.A. Maryland | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SON'S MORTUARY, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1983 | | 25b. REGISTRAR'S SIGNATURE <i>John S. [Signature]</i> | |

BP.

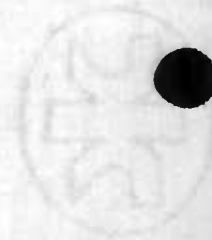
JAMES JOHNSON 11-11-83 2:22PM

PRINCE GEORGE'S COUNTY
NURSING CARE CENTER

THOMAS
JAMES

11-11-83
11-11-83

11-11-83
11-11-83



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25148

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Robert

M.

Johnson

2a. DATE KNOWN OF DEATH
ESTIMATED ☒ 9 2 19 83 2b. HOUR
M

3. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

MONTH

DAY

YEAR

8 25 37

6. AGE (IN YEARS)

LAST BIRTHDAY

46 YRS.

IF UNDER 24 YRS.

MONTHS

DAYS

HOURS

MIN.

2c. DATE PRONOUNCED DEAD

MONTH

DAY

YEAR

9 2 19 83

2d. HOUR

9:05 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Wash., D.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's County, MD

10. CITY OR TOWN OF DEATH

Hyattsville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6100 blk. Ager Road

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Painter

12b. KIND OF BUSINESS OR INDUSTRY

Private

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

D.C.,

13b. STATE

13c. COUNTY

Washington

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1101 7th Street, NE

14. FATHER'S NAME

Matthew

MIDDLE

Johnson

LAST

15. MOTHER'S MAIDEN NAME

Fannie

MIDDLE

Geter

EAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

Yes

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

577-50-7846

17. INFORMANT

Margaret Haynes 1101 7th St., NE

ADDRESS Wash., D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a)

Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 9-3-83

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

9/9/83

23c. NAME OF CEMETERY OR CREMATORY

Harmony Mem. Park

23d. LOCATION

Landover, Maryland

COUNTY

STATE

24. FUNERAL DIRECTOR

MARSHALL FUNERAL HOME

ADDRESS

4217 9th St., NW

Washington, DC

25a. DATE REC'D. BY REGISTRAR

SEP 13 1983

25b. REGISTRAR'S SIGNATURE

Dennis F. Smyth



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

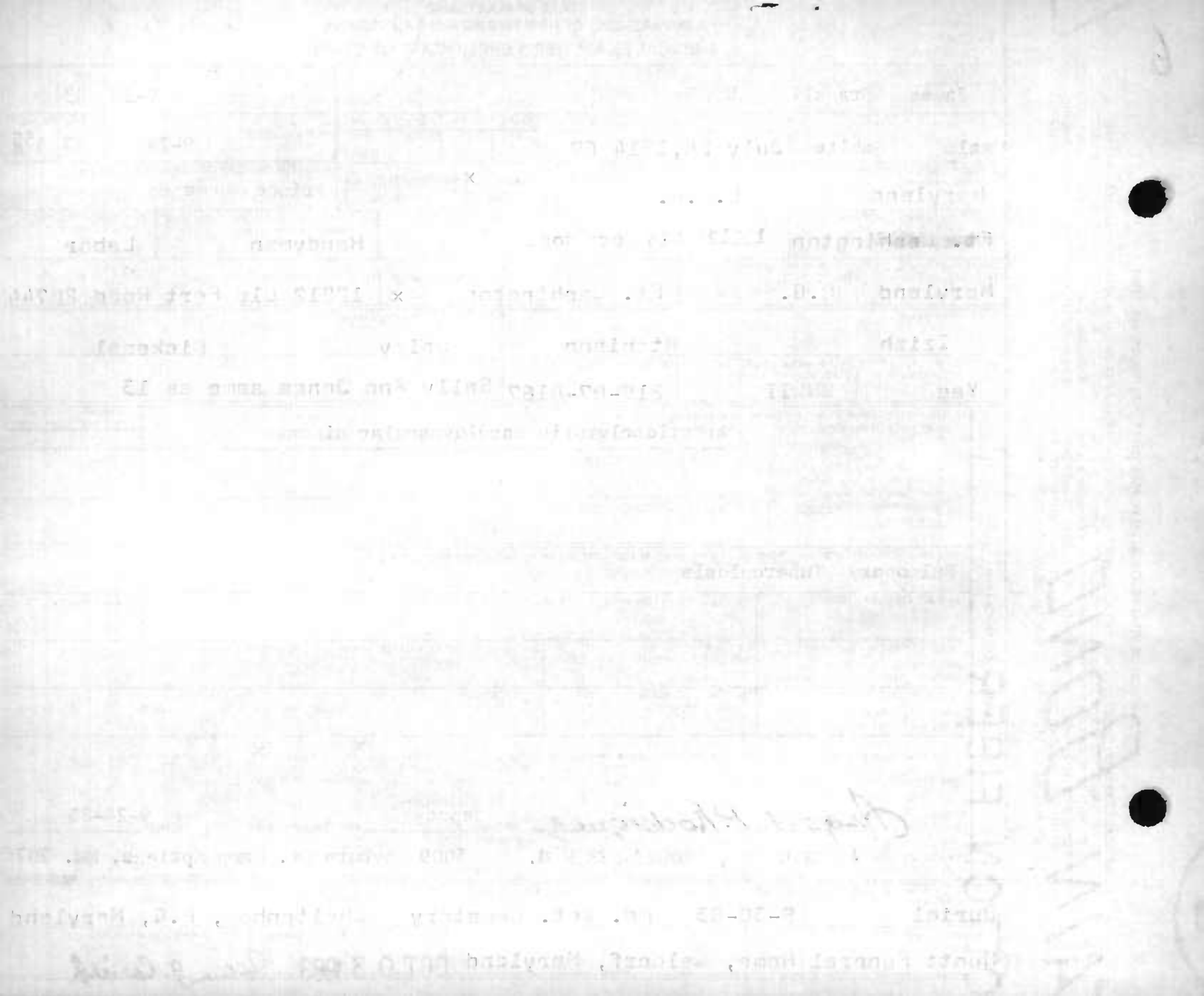
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25149

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|-------------------------|---|---|---|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) James Franklin JONES | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 9 DAY 28 YEAR 83 | | | 2b. HOUR 4:55 AM | | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH MONTH July DAY 28 YEAR 1914 | 6. AGE (IN YEARS) LAST BIRTHDAY 69 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH 9 DAY 28 YEAR 83 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | |
| 10. CITY OR TOWN OF DEATH Ft. Washington | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (GIVE STREET ADDRESS) 12212 Old Fort Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Handyman | | 12b. KIND OF BUSINESS OR INDUSTRY Labor |
| 13a. STATE Maryland | | | 13b. COUNTY P.G. | 13c. CITY OR TOWN Ft. Washington | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 12212 Old Fort Road 20744 | | |
| 14. FATHER'S NAME FIRST Iziah MIDDLE LAST Atchison | | | | 15. MOTHER'S MAIDEN NAME FIRST Daisy MIDDLE LAST Pickeral | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. 219-07-8167 | | 17. INFORMANT ADDRESS Sally Ann Jones same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pulmonary Tuberculosis | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | TITLE (SPECIFY) Deputy M.D. | | MEDICAL EXAMINER | | DATE SIGNED 9-28-83 | |
| EXAMINER'S NAME (TYPE OR PRINT) AUGUSTO P, RODRIGUEZ, M.D. | | | ADDRESS 5009 Rayburn Ct. Camp Springs, Md. 20744 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-30-83 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cemetery | | 23d. LOCATION CITY OR TOWN Cheltenham COUNTY P.G. STATE Maryland | | |
| 24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | 25b. REGISTRAR'S SIGNATURE James J. Carney | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian S. Jones | | | 2a. DATE OF DEATH MONTH DAY YEAR September 11, 1983 | | 2b. HOUR P 3:38 |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR MAY 12, 1908 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | |
| 10. CITY OR TOWN OF DEATH LAUREL | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHOTO FINISHER | 12b. KIND OF BUSINESS OR INDUSTRY PEOPLES DRUGS | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY PRI. GEORGES | 13c. CITY OR TOWN BELTSVILLE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST GUY SMITH | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMELIA WEISS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-5311 | 17. INFORMANT ADDRESS LORRAINE J. FLETCHER SAME AS 13 DAUGHTER | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST 5860 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-31 , 19 83 , to 9-11 , 19 83 that (I) (we) last saw the deceased alive on 9-11 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) M. H. CHAUDHRY, MD | | | | 22c. DATE SIGNED NO ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. ADDRESS 14201 Laurel Rd Drive, Laurel, Maryland, 20707 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 9/15/83 | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C. | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Smith | |

BP

Radio Interview Report
Subject: [illegible]
Date: [illegible]

X

4-11-43 - 11-43

Mr. [illegible]
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) RICHARD E. JONES | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 21 83 | | | 2b. HOUR 10:08PM | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 19, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheetmetal | | 12b. KIND OF BUSINESS OR INDUSTRY Building | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | 13b. COUNTY Prince Geo | | 13c. CITY OR TOWN Capital Hgts | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 716 Ritchie Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank nm Jones | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane A Hurley | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11 | | 17. INFORMANT 4209 Southend Rd Helen Jones Postorino, Rockville, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY FAILURE | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-21 , 19 83 , to 9-21 , 19 83 , that (I) (we) last saw the deceased alive on 9-21 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE RAJ. SAMTANI | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-22-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJ. SAMTANI | | | | | 22e. ADDRESS 9015 Woodyard Rd. CLINTON, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-26-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. George, Md | | | |
| 24. FUNERAL DIRECTOR W. W. Chambers Co, 8655 Georgia Ave Silver Spring, Md. 20910 | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1983 | | 25b. REGISTRAR'S SIGNATURE J. L. ... | | |

BP _____

THE UNIVERSITY OF CHICAGO
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROSA D JONES | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 02 83 | | | 2b. HOUR 3:15A.M. | | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR March 28, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH Anton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE D. C. | | 13b. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5075 Just St., N.E., Washington, D.C. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST W. E. Ward | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bettie White | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 17a. SOCIAL SECURITY NO. 228-09-2399 | | | 17b. INFORMANT (Mrs) Kathryn J. Taylor - (Daughter) | | | 17c. ADDRESS 5075 Just St., N.E., Washington, D. C. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Spontaneous Aortic Rupture DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma of Colon - Cerebrovascular accident | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/29 , 19 83 , to 9/2 , 19 83 , that (I) (we) lost saw the deceased alive on 9/1 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE R. E. 2A | | | | | | DEGREE | | 22c. DATE SIGNED 9/2/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. E. 2A | | | | | | 22e. ADDRESS 4235 26th Ave NW 20795 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept. 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Thornrose Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Staunton, Virginia | | |
| 24. FUNERAL DIRECTOR NAME Reuben Baker | | | | | | 25a. DATE RECEIVED BY REGISTRAR SEP 8 1983 | | | |
| 24b. ADDRESS Staunton, Virginia | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

| | | | |
|----------|-------------|---------------------------------------|---------------------------------------|
| Female | Married | March 28, 1902 | 51 |
| Virginia | U S A | X | |
| | | | Domestic |
| D. C. | Washington | X | 2075 First St. N.E., Washington, D.C. |
| W. | Ward | Beale | White |
| No | 228-70-2390 | 2075 First St. N.E., Washington, D.C. | (Mrs) Margaret J. Taylor - (Daughter) |

Serial
 Jones Sumrell
 2075 First St. N.E., Washington, D.C.
 2075 First St. N.E., Washington, D.C.
 2075 First St. N.E., Washington, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER. RETAIN PAGE 7. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25153 | | |
|--|-------------------------|---|---|--|--|--|--|--|--|---|--|----------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTONIO JUDGE | | | | | | | | | | 2a. DATE OF DEATH KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9-30-83 | | 2b. HOUR 1:59 PM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 9-14-83 | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 16 | IF UNDER 1 YR. MONTHS DAYS 16 | IF UNDER 24 HRS. HOURS MIN. 16 | 2c. DATE PRONOUNCED DEAD 9-30-83 | | 2d. HOUR 1:59 PM | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependent | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | | |
| 13a. STATE Maryland | | 13b. COUNTY PG | | 13c. CITY OR TOWN Capitol Hts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 622 Balboa Avenue | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ronald Miller | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tonie Judge | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. none | | 17. INFORMANT Tonie Judge | | ADDRESS Same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) Sudden infant death syndrome DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 10-1-83 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10-7-83 | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md | | | | |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm | | | | | | ADDRESS Suitland, Md. | | 25a. DATE RECEIVED BY REGISTRAR OCT 13 1983 | | 25b. REGISTRAR SIGNATURE <i>John J. Carver</i> | | |

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

2

INDEX

RECEIVED



RELEASED BY CORONER - DR. DAEI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25154 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Audrey KABRAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 8, 1983 | | 2b. HOUR MIN. 10:17a.m. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR February 6, 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 45 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | |
| 10. CITY OR TOWN OF DEATH LANHAM | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. Co. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Berwyn Heights | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Benjamin | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frieda Popkin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | |
| | | 16b. SOCIAL SECURITY NO. 577-52-3481 | | 17. INFORMANT ADDRESS Byron Kabran (Same as # 13) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiopulmonary Arrest</u> 4939 DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRONCHIAL ASTHMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Hrs. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Jan 1, 1983, to Sept 8, 1983, that (1) (we) lost saw the deceased alive on Sept 7, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Robert Ruderman MD | | | | DEGREE MD | | 22c. DATE SIGNED 9/8/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Ruderman, MD | | | | 22e. ADDRESS 6201 Greenbelt Rd. College Park. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/11/1983 | | 23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden | | 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia | |
| 24. FUNERAL DIRECTOR Dorinda M. Stein Hebrew Memorial Funeral Home 232 Carroll Street, N. W., Washington, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

RECEIVED
JAN 17 1964
FBI - NEW YORK

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]



RECEIVED
JAN 17 1964
FBI - NEW YORK

20% COTTON

7

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) KATHLEEN MARIE KELLY | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 9-11-83 | | 2b. HOUR 4AM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Sept. 12, 1958 | | 6. AGE (IN YEARS) 24 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD 9-11-83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ft. Bragg, N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County | | | 10. CITY OR TOWN OF DEATH Beltsville | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse Practitioner-Medical | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. STREET ADDRESS 21229. 527 Nottingham Road | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 527 Nottingham Road | | 13f. STREET ADDRESS 527 Nottingham Road | |
| 14. FATHER'S NAME Edward M. Kelly | | | | 15. MOTHER'S MAIDEN NAME Patricia Byrd | | | | 16. SOCIAL SECURITY NO. 212-60-9130 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 212-60-9130 | | | | 17. INFORMANT Dr. Edward M. Kelly , ADDRESS Baltimore, Md. - 21229. Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral injuries 8191 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY 4AM 9-11-83 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) occupant involved in automobile accident | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy. | | | | 21f. LOCATION 95d Vanness Prince George's Co., Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 9-12-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/13/83 | | | | 23c. NAME OF CEMETERY OR CREMATORY Kelly Family Cenetery- Carroll County, Md. | | | |
| 24. FUNERAL DIRECTOR Sterling Funeral Estate, P. A. | | | | 24a. DATE REC'D BY REGISTRAR SEP 14 1983 | | | | 24b. REGISTRAR'S SIGNATURE J. A. J. Canine | | | |
| 25. ADDRESS 736 Edmondson Ave. Catonsville, Md. 21228 | | | | | | | | | | | |



ORIGINAL
RECEIVED
MAY 11 1961
U.S. AIR FORCE
OFFICE OF THE
SECRETARY OF THE
AIR FORCE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR Item 18c film 584 STATE REGISTRAR 10-4-83 cn | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 25156 REG. NO. | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) William Edward Kerwin Sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 06, 1983 | | | | 2b. HOUR P 5:30 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR August 26, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) engineer assistant | | 12b. KIND OF BUSINESS OR INDUSTRY physics lab | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 10940 Johns Hopkins Road 20707 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Humphrey Kerwin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Virginia Verts | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. 220 24 5973 | | 17. INFORMANT ADDRESS Lillian Kerwin same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transition + Cachexia</u> <u>2030</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Myeloma</u> (c) <u>Hyperviscosity Syndrome</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Immune Deficiency 20% Myeloma; Pancreatic</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> , 19 <u>83</u> , to <u>9/6</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/4</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert Ruderman</u> | | | | DEGREE <u>MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9/7/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robt Ruderman, MD</u> | | | | 22e. ADDRESS <u>6201 Greenbelt Rd, College PK</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept. 9, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY St Pauls Lutheran Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Fulton Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u> | | | | | |



1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the President's message to the Congress, and is one of the most important documents in the history of the United States. The letter is written in a very formal and dignified style, and is one of the most important documents in the history of the United States. The letter is written in a very formal and dignified style, and is one of the most important documents in the history of the United States.

2. The second part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the President's message to the Congress, and is one of the most important documents in the history of the United States. The letter is written in a very formal and dignified style, and is one of the most important documents in the history of the United States. The letter is written in a very formal and dignified style, and is one of the most important documents in the history of the United States.

3. The third part of the document is a letter from the President of the United States to the Congress, dated January 1, 1863. It is a very important document, as it contains the President's message to the Congress, and is one of the most important documents in the history of the United States. The letter is written in a very formal and dignified style, and is one of the most important documents in the history of the United States. The letter is written in a very formal and dignified style, and is one of the most important documents in the history of the United States.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| FIRST MIDDLE LAST | | 9-6-83 | | 3 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| FE | | Black | | MONTH DAY YEAR | |
| | | | | 08 10 1896 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| North Carolina | | USA | | 87 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Laurel | | GREATER LAUREL NRS. HOME | | PRINCE GEORGES MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Homemaker | | None | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| D. C. | | V | | Washington | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Monroe | | Barringer | | Annie Barber | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 577-36-147 | | Mrs. Geraldine Taylor /daughter/ same as 13c | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4360 | | CARDIO PULMONARY ARREST | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) | | CEREBROVASCULAR OCCLUSIVE DISEASE | |
| | | (c) | | CEREBROVASCULAR ACCIDENT REMOTE | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION | |
| | | | | STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (his hospital) attended the deceased from 11 March 19 82, to 6 Sept 19 83, that (1) (we) last saw the deceased alive on 8/11/83 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| J. A. Compton | | MD | | 9/6/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| GREGORY A. COMPTON MD | | 4201 LAUREL PARK DR # 104 | | LAUREL MD 20707 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9-10-83 | | Harmony Memorial Pk. | |
| | | | | Landover, Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | 20 SEP 13 1983 | | John T. Rhines Co., 3015 12th St. N.E., D.C. | |
| John T. Rhines Co., 3015 12th St. N.E., D.C. | | | | | |

RECEIVED
JAN 10 1963
U.S. AIR FORCE
HEADQUARTERS
HONOLULU, HAWAII

10

TO: SAC, NEW YORK
FROM: SAC, HONOLULU
SUBJECT: [Illegible]
[Illegible text follows]

[Illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) James Robert King | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 6, 1983 | | | | 2b. HOUR 7:00 PM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1927 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 56 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 0 0 | | 8. IF UNDER 72 HRS. HOURS MIN. 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hosp. of Pr. Geo. Co. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Acct. | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN New Carrollton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Zip Code - 20784 8311 Donoghue Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederic King | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mann | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Army | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 578-30-6045 | | 17. INFORMANT Mrs. Betty A. King | | ADDRESS Address Same as No# 13e. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Anterograde Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 6 yrs | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/7/83 , 19 83 , to current , 19 83 , that (I) (we) lost saw the deceased alive on 7/27 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Roger B. Ingham | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED Sept. 7, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger B. Ingham, M.D. | | | | 22e. ADDRESS 5701 85th. Ave. New Carrollton, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE Sept. 9, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons | | | | 24b. ADDRESS F.H. P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Casper | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|------------------|--|---|-----------------------------------|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lottie C. Kingsbury | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9-27 1983 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept 7, 1888 | | 6. AGE (IN YEARS) LAST BIRTHDAY 95 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-27 1983 | | 7b. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | |
| 10. CITY OR TOWN OF DEATH Clinton | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Cntr. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY Federal Employee | |
| 13a. STATE Maryland | | | 13b. CITY OR TOWN PG | | 13c. CITY OR TOWN Temple Hills | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4037 Lyons Street 20748 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Comstock | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Slama | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -- | | 17. INFORMANT H. Kenneth Kingsbury | | | ADDRESS Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8880 IMMEDIATE CAUSE (a) Hip fracture with complications DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 P.M. 9-26 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fall in bedroom | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4037 Lyons St., Temple Hills, P. George, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | M.D. <i>Signature</i> | | | | MEDICAL EXAMINER | | DATE SIGNED 9-27-83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10-3-83 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Omaha Nebraska | | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm | | | | ADDRESS Funeral Home Suitland, Md. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 3 1983 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Signature</i> | | | |

BP

My first was with a companion

10-2-23 23 full in bed

10-2-23 23 full in bed

10-2-23 23 full in bed



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant on page 3, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|---|--|--|-----------|--|---|---|-----------------------|--|-----------------------------------|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | 7b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | | 2b. DATE OF DEATH MONTH DAY YEAR | | | | | | | 7b. HOUR | |
| JAMES ANDREW KOWALSKI, Sr. | | | | | SEPTEMBER 06 1983 | | | | | | | 0323 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| MALE | | WHITE | | SEPTEMBER 26 1918 | | 64 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| WASHINGTON D.C. | | UNITED STATES | | | | PRINCE GEORGE'S COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| ANDREWS AFB | | MALCOLM GROW USAF MEDICAL CENTER | | | | ENGINEER | | | Bendix Co. | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 23609 NECK ROAD 20608 | | | | | |
| MARYLAND | | PRINCE GEORGE | | Aquaasco | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| STEPHEN Lewis KOWALSKI | | | | | MARTHA ELIZABETH FREELAND | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| YES | | | | | WW II | | 579-03-0213 | | | | | | |
| | | | | | MICHAEL STEPHEN KOWALSKI, ROCKVILLE MD 2085 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> | | | | | | | | | | | | | |
| 1889 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic bladder cancer</u> | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11 JULY</u> , 19 <u>83</u> , to <u>06 SEPTEMBER</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>06 SEPTEMBER</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE DEGREE | | | | | | | | 22c. DATE SIGNED | | | | | |
| William S. Sykora M.D. | | | | | | | | 06 SEPTEMBER 8 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e. ADDRESS | | | | | |
| WILLIAM S SYKORA | | | | | | | | MALCOLM GROW USAF MED CEN AAFB, MD 20331 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | 9-9-83 | | Md. Vet. Cemetery | | | Cheltenham, P.G., Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Hunt Funeral Home, Waldorf, Maryland | | | | | | | | SEP 13 1983 | | J. Carol | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MAMIE LANGLEY | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 06 83 | | | 2b. HOUR 9:14A M | | | |
| 3. SEX Female F | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 25 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. STATE M D . . | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN 9300 Edmondson Rd. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Hall | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Sowell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-24-3672 | | 17. INFORMANT ADDRESS Esmond Langley 1440 Rockcreek Church | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardiopulmonary arrest**
5698
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) **septic shock**
(c) **bowel perforation**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 hr.**36 hrs****3 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Probable ovarian carcinoma

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION 9/5/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel perforation | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 15 83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) g/s | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19 | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3100 Anth Way, GHA, Landover, Md | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/5 to 9/6 , 19 83 , that (I) (we) lost saw the deceased alive on 9/6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Lise A Golders | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/7/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lise A Golders | | 22e. ADDRESS 3100 Anth Way, GHA, Landover, Md | | | | | |

| | | | | | | | |
|---|--|--------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10 Sept 83 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Nat. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover, MD. | |
| 24. FUNERAL DIRECTOR NAME FRAZIER'S FUNERAL HOME 389 R.I. Ave. N | | | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | 25b. REGISTRAR'S SIGNATURE John E. Carver | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

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NAME

PRINCE GEORGES

PRINCE GEORGES GENERAL HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 25162 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRVING MARCUS LEE | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 15, 1983 | | 2b. HOUR 6:39a M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR NOV. 3, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | |
| 10. CITY OR TOWN OF DEATH LANHAM | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) T.V. REPAIRMAN | | 12b. KIND OF BUSINESS OR INDUSTRY TELEVISION | |
| 13a. STATE MARYLAND | | 13b. COUNTY P.G. County | | 13c. CITY OR TOWN BOWIE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MARCUS - LEE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE - ROSENFELD | | 13e. STREET ADDRESS 15713 POINTER RIDGE DRIVE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS 087-07-4759 ETHEL N. LEE (WIFE) SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory insufficiency</u> 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Stage IV colon ca.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/11/83</u> , 19 <u>83</u> , to <u>9/15</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/14/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Sophia Untiveros, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/15/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sophia Untiveros, M.D. | | | | 22e. ADDRESS 9811 Mallard Dr. PO2585, Laurel, Md. 20708 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE SEPT. 15, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, P.G. CO. MARYLAND | |
| 24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME RIVERDALE, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 21 1983 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH MAE LEIBRAND | | | | 2b. HOUR 8:30A M | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 20 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | |
| 10. CITY OR TOWN OF DEATH Camp Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse - Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Nursing | |
| 13a. STATE Maryland | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN Temple Hills | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John T. Shapbell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eve V. Gable | | 13e. STREET ADDRESS 2702 Old Barnaby Road | | 20748 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 206-10-7893 | | 17. INFORMANT ADDRESS Josephine E. Dresher 2702 Old Barnaby Road Temple Hills, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF (c) Malignant Metastatic Breast Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 1749 | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 minutes | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 Sept 19 83 to 2 Sept 19 83 , that (I) (we) lost saw the deceased alive on 2 Sept 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joseph D. Dye | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2 Sept. 83 | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH D. DYE, CAPT, USAF, MC | | 22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER AAFB MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/7/83 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Virginia | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas | | 6160 Oxon Hill Rd. Oxon Hill, Md. | | 25. DATE RECEIVED BY REGISTRAR SEP 13 1983 | | 25. REGISTRAR'S SIGNATURE John J. [Signature] | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25164

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Ernest LESTER | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 16 83 | | 2b. HOUR 8:15PM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR March 10, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | 13b. COUNTY Prince Geo | 13c. CITY OR TOWN Upper Marlboro | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2300 Crain Highway | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence Lester | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Willis | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 236-05-3156 | | 17. INFORMANT ADDRESS Abigail Parker 2300 Crain Highway | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Ischemic Heart Disease**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Chr. Congestive Heart Failure**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Diabetes Mellitus; Generalized atherosclerosis

| | | | | | |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/21/78 to Sept. 16th 83 , that (I) (we) last saw the deceased alive on Sept. 13th, 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Victor S. Chupkovich | | DEGREE | | 22c. DATE SIGNED 9-19-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor S. Chupkovich, M.D. | | 22e. ADDRESS 9131 Piscataway Rd., Clinton, Md. 20735 | | | |

| | | | |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9-22-83 | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS Marshall's Funeral Home 4217 9th Street NW: Washington, D.C. | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1983 REGISTRAR'S SIGNATURE John J. Gaudin | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Handwritten signature or initials.

Vertical text, possibly a date or reference number.

Horizontal text at the bottom of the page, possibly a footer or address.

10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25165 | |
|--|--|--|--|--|---|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Catherine V. Lindsay | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | 2b. HOUR | | |
| 3. SEX female | | | | | | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR June 28, 1924 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | | | | | | 7. IF UNDER 1 YR. MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | | | | | | | 10. CITY OR TOWN OF DEATH Seat Pleasant | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6610 Greig St. Apt. 303 | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bar Tender | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | | | | | | 13b. CITY OR TOWN P.G. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13d. STREET ADDRESS 6610 Greig Street, Apt. #303 | | | | | | | 14. FATHER'S NAME FIRST MIDDLE LAST Ernest Partt | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanch C. Griffin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | | | | 16b. SOCIAL SECURITY NO. 143 18 3196 | | 17. INFORMANT Phillip M. West-252 Harry S. Truman Drive, Largo, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>Hypertensive Aortic Aneurysm Rupture</i> IMMEDIATE CAUSE: <i>4029</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>chronic</i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | | DATE SIGNED 9-11-83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE Sept 17, 1983 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | |
| 23d. LOCATION CITY OR TOWN Washington, D.C. | | | | | 23e. COUNTY | | | | | 23f. STATE | |
| 24. FUNERAL DIRECTOR Stewart Funeral Home | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i> | |

18

11

Hyphomys sublineatus
Blanford

Hyphomys

5000 YAMUO, L. T. 10.10.11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25166

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Nellie J Long | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept 9 1983 | | | 2b. HOUR 7:00 P/M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 4 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bureau of Engrav. | | 12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't. | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Oxon Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7907 Indian Head Highway 20745 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jeremiah McCarthy | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Deery | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-44-7576 | | 17. INFORMANT ADDRESS Edwina E. Cecchini 4407 Lakeview Dr. 20748 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of ovary 1809 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) with metastatic DUE TO, OR AS A CONSEQUENCE OF (c) spread | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MONS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic heart disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Sept 9 19 83 , to Sept 9 19 83 , that (I) (we) lost saw the deceased alive on Sept 9 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death) | | | | | | | | | |
| 22b. SIGNATURE Herbert Wisotsky | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-10-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert Wisotsky, M.D. | | | | 22e. ADDRESS 6188 Oxon Hill Rd., Oxon Hill, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-13-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home | | | | ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |

BP

THE UNIVERSITY OF CHICAGO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|-------------------------|---|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Mark A. Lynch | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 13 1983 | | | 2b. HOUR 11:30 a.m. | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1965 | 6. AGE (IN YEARS) LAST BIRTHDAY 17 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 9 13 1983 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, Md. | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | 12b. KIND OF BUSINESS OR INDUSTRY College |
| 13a. STATE Maryland | | | 13b. COUNTY P.G. | 13c. CITY OR TOWN Landover Hills | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Donald M. Lynch | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nola Craven | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217-92-5631 | | 17. INFORMANT ADDRESS 7513 Buchanan St Mr. Donald M. Lynch Landover Hills, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 Multiple Injuries IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:20 a.m. 9 13 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in auto/tractor trailer impact | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Good Luck Rd. near I-95, Bowie, Prince George's Co., Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | TITLE (SPECIFY) Assistant | | | DATE SIGNED 9-14-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept. 16, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Riverdale Mem. Gardens Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Largo P.G. Maryland | |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyatts. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1983 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Carroll</i> | |

BP

• **WELSH** •

FD-302 (Rev. 4-15-64)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

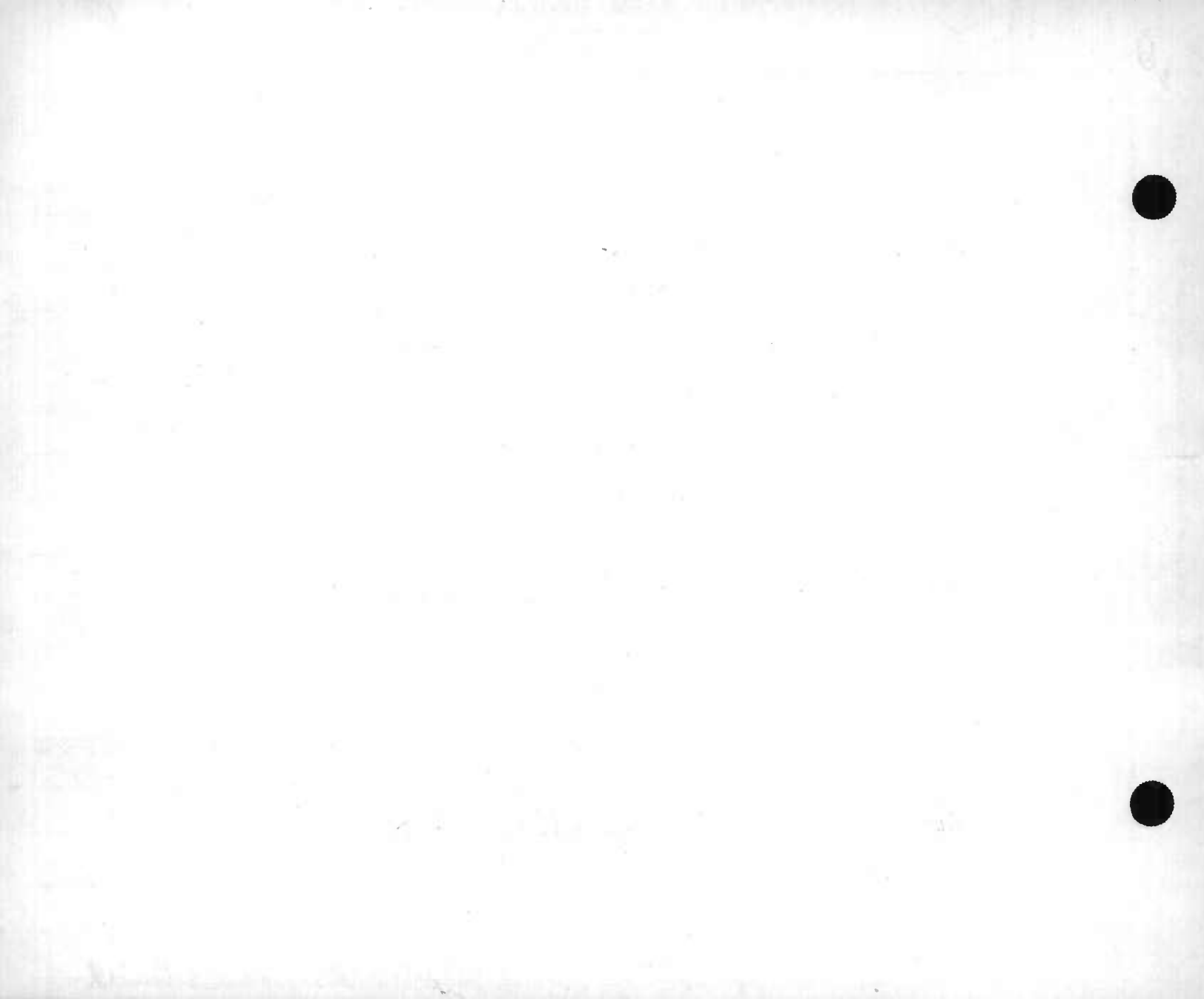
| | | | | | |
|---|--|--|--|---|---|
| Items 2a, 5, Film# G584 - | | STATE OF MARYLAND | | 25168 | |
| 1- FOR 10-6-83jlb STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Stephen William Lyon</i> | | 2a. <i>9-25-83</i> MONTH DAY YEAR | | 2b. HOUR <i>6:30 A</i> | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. <i>Nov. 4, 1924</i> MONTH DAY YEAR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS. MONTHS DAYS HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH <i>Clinton</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Md. Hospital Center</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | |
| 13a. STATE <i>Maryland</i> | | 13b. CITY OR TOWN <i>Charles White Plains</i> | | 13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John A. Lyon</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha G. Irwin</i> | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Driver</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i> | | 16b. SOCIAL SECURITY NO. <i>WW II</i> | | 17. INFORMANT <i>2004-15th Amberleaf Place</i> <i>Margaret McGuigan Waldorf, Maryland</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Failure</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Carcinoma of Esophagus</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>con 1 2y</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8-9</i> , 19 <i>76</i> , to <i>9-24</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>9-22</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Richard N. Dobson M.D.</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>9-24-83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Richard Dobson, M.D.</i> | | 22e. ADDRESS <i>Brandywine, Maryland 20613</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>9-28-83</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Rest Cemetery</i> | |
| 23d. LOCATION CITY OR TOWN <i>La Plata, Charles, Md.</i> | | 23e. DATE REC'D. BY REGISTRAR <i>SEP 27 1983</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>Hunt Funeral Home, Waldorf, Maryland</i> | | 24b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edna Mae Major | | | | September 25, 1983 | | | |
| 3 SEX Female | | 4 RACE Negro | | 5 DATE OF BIRTH MONTH DAY YEAR June 2, 1907 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. 76 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | |
| 10 CITY OR TOWN OF DEATH Temple Hills | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2343 Kenton Place | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Typist | | 12b. KIND OF BUSINESS OR INDUSTRY Government | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN D.C. Washington | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Information not available | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Arledge Aldridge | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-09-0032 D | | 17. INFORMANT Temple Hills, Maryland 20748 Jessica N. King, daughter, 2343 Kenton Place | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 1790 IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Uterine Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Athlerosclerotic Heart Disease/Aortic Stenosis/Diabetes | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (we) (we) attended the deceased from November 1980, to September 25, 1983, that (I) (we) last saw the deceased alive on September 19, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Dr. Rodriguez, Med. Ex., notified and approved | | | | | | | |
| 22b. SIGNATURE Marilyn C. Coruzzi MD | | | | 22c. DATE SIGNED September 25, 1983 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marilyn C. Coruzzi, M. D. | |
| 22e. ADDRESS 1780 Mass. Ave. NW, Washington, D. C. 20036 | | | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 30, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland | |
| 24. FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc. Washington, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | | |
| 25b. REGISTRAR'S SIGNATURE J. C. Coruzzi | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25170 | |
|--|-------------------------|---|---|---|--------------------------------|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) James Mallory | | | | | | 2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> 9 20 1983 | | 2b. HOUR 9:23 P.M. | | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 12 9 47 | 6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 9 20 1983 | | 2d. HOUR 9:23 P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 21207 1958 W. Virginia Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William F. Mallory | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Clark | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 242-78-9072 | | 17. INFORMANT ADDRESS Mary V. Mallory RT. 2 Box 302 A. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Blunt trauma to Chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR 9:20 P.M. MONTH DAY YEAR 9 20 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in auto/auto impact | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Balto. Ave. & Edgewood St. College Pk., Prince George's Co., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Dennis F. Smyth</i> | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 9-21-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | | 23b. DATE 9-24-83 | | 23c. NAME OF CEMETERY OR CREMATORY Twilight Bapt. Ch. Cem | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Halifax Co., N.C. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc. 1101 E North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i> | | | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

CHIEF OF BUREAU
JAN 21 1964

215

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25171 | |
|---|--------------------------|---|---|--|---|---|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) George Kazman MARIAS | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR 9-28 1983 | | 2b. HOUR M | | | |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH June DAY 16 YEAR 1938 | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 9-28 1983 | | 7d. HOUR M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Temple Hills | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5021 Temple Hills Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY Electric | | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN Temple Hills | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5021 Temple Hills Road 20748 | | | |
| 14. FATHER'S NAME FIRST Emil MIDDLE LAST Marias | | | | 15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE LAST Milinkovich | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 230-46-1429 | | 17. INFORMANT Emil Mariast ADDRESS 5021 Temple Hills Road Temple Hills, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy 4254 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Ethyl hem (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | TITLE (SPECIFY) Deputy M.D. | | | MEDICAL EXAMINER | | DATE SIGNED 9-28-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. | | | 20748 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/30/83 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Cemetery | | 23d. LOCATION CITY OR TOWN Alexandria COUNTY Va. STATE Va. | | | | | |
| 24. FUNERAL DIRECTOR NAME G.P. Kalas ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1983 | | 25b. REGISTRAR'S SIGNATURE Sam J. Curren | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL M. MARQUETTE | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-11-83 2b. HOUR 7:30PM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 22 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Md. | 13b. COUNTY PG | 13c. CITY OR TOWN Dist. Hgts. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1801 Brewton Court 20747 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edwin N. Fairall | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel M. Dearstine | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 579-26-1433 | | 17. INFORMANT ADDRESS Frank W. Marquette, Husband, Same as Above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure 1749 DUE TO, OR AS A CONSEQUENCE OF myocardial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial DUE TO, OR AS A CONSEQUENCE OF myocardial infarction (c) myocardial infarction | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 9/11 19 83 to 9/11 19 83 , that (1) (we) last saw the deceased alive on 9/11 19 83 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Lewis Dennis | | DEGREE | | 22c. DATE SIGNED 9/12/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS DENNIS, M.D. | | 22e. ADDRESS 831 UNIVERSITY BLVD. SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-15-83 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, PG, MD |
| 24. FUNERAL DIRECTOR NAME Wilhelm F. Suitland, Md | | Funeral Home ADDRESS | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | |
| | | | | REGISTRAR'S SIGNATURE John J. [Signature] | |

BP

LEWIS DAVIS, M.D.

831 UNIVERSITY BLVD., SILVER SPRING, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25173

| | | | | | | | | | | |
|---|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RUTH M. MARTIN | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT. 22, 1983 | | | 2b. HOUR 1:15 AM | | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR October 10, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL | | | | 12a. USUAL OCCUPATION (LAST OF WORKING LIFE) Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY School of Nursing | | |
| 13a. STATE Maryland | | | 13b. COUNTY Pr. George's | | 13c. CITY OR TOWN Bowie | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 3032 Belair Drive 20715 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence R. Martin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irma Mutchler | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 191-22-4033 | | 17. INFORMANT Reba R. Sheppard | | ADDRESS 3032 Belair Drive Bowie, Maryland 20715 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myo Cardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1981 , to 9-22 , 19 83 , that (we) last saw the deceased alive on 9-21- , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE William A. Warren, MD | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/22/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. A. Warren | | | 22e. ADDRESS 321 Prince George St Laurel, MD 20707 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept 26, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Valley Forge Mem. Gard. | | 23d. LOCATION CITY OR TOWN COUNTY STATE King of Prussia, Montgomery, PA | | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home | | | 16000 Annapolis Road Bowie, Maryland 20715 | | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | |

2601-S3-107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Martinez | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 21, 1983 | | | | 2b. HOUR 9:22 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR October 4, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Guatemala | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE District of Columbia | | 13b. CITY OR TOWN Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS 635 Edgewood Street, N.E. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Martinez | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marcellina Arrazola | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 095-14-6160 | | 17. INFORMANT ADDRESS MIMI SWINGLISH, FRIEND, 3725 WARREN ST., N.W., WASHINGTON, D.C. 20016 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAINSTEM STROKE 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBROVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ATHEROSCLEROTIC DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS YEARS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from JUNE 16, 1983 to SEPTEMBER 21, 1983 , that (I) was lost saw the deceased alive on SEPTEMBER 21, 1983 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Marta Schneider M.D. | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/21/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTA ANNE SCHNEIDER M.D. | | | | 22e. ADDRESS 201-Pth St. N.E. WASH. D.C. 20002 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 9/26/83 | | 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA | | | | | |
| 24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. WASHINGTON, D.C. 20036 | | | | 24a. DATE REC'D. BY REGISTRAR SEP 27 1983 | | 24b. REGISTRAR'S SIGNATURE R. C. C. C. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | 83 25175 | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Viola T. Massey | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 25 83 | | 2b. HOUR 7:30 P M |
| 3. SEX FEMALE | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 6 17 17 | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | |
| 10. CITY OR TOWN OF DEATH Riverdale | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. CITY OR TOWN Pr. Geo. | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 4600 Tuckerman Street 20737 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Aaron ? | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 421-20-7784 | | 17. INFORMANT ADDRESS Mamie Jackson (daughter) same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1820 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiorespiratory arrest. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } Endometrial with metastases DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic heart disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-16-1983, to 9-24-1983, that (I) (we) last saw the deceased alive on 9-6-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A BRAHAM DABELA | | 22e. ADDRESS 4404 Queensbury Rd. Riverdale MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-29-83 | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Pr. Geo, Md. |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | 24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 03 1983 <i>[Signature]</i> | |

BP

CHIEF

20% COLL



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25176

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|------------------------------|--|---|--|--|--|-------------------------------|--|--|--|---------------------------|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. DATE OF DEATH | | | | 2c. DATE PRONOUNCED DEAD | | | | 2d. DATE OF DEATH | | | | | | | | | | | | | | | |
| John E. Mayo | | | | 9 10 87 | | | | 9 10 87 | | | | 9 10 87 | | | | 9 10 87 | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST DAY) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| M | | B | | Oct. 11, 1921 | | 61 | | | | | | P.D. Co | | District Heights | | Prince George's General Hosp. | | Retired | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Virginia | | | | USA | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Maryland | | | | P.G. | | | | Capitol Hgts. | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 412 Milford Dr. | | | | John E. Mayo | | | | Stella Haney | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 16c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 16d. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 16e. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 16f. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 16g. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | |
| no | | | | 578 16 6475 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4148 IMMEDIATE CAUSE (a) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | |
| | | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE SAID A. DABNEY | | | | | | | | | | M.D. Deputy | | | | | | | | | | DATE SIGNED 9-10-87 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) 5632 Annapolis Rd | | | | | | | | | | ADDRESS Bladensburg MD 20710 | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | |
| Burial | | | | | | | | | | Sept. 14, 1983 | | | | | | | | | | Harmony Memorial Park Landover, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Stewart Funeral Home | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| 4801 Benning Road, N | | | | | | | | | | SEP 22 1983 | | | | | | | | | | John J. Casper | | | | | | | | | | | |

12 H

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| Item 16b, Film #G586 - STATE OF MARYLAND - DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25177 REG. NO. | |
|---|--|------------------|---|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Catherine M. McCarthy | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 20 1983 | | | 2b. HOUR 1:06 P. M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 14, 1913 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 69 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 20 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD | | |
| 10. CITY OR TOWN OF DEATH Riverdale | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7107 Wells Parkway 20782 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank G. Muckelbauer | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa D. Speckert | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-01-5009 | | | 17. INFORMANT Daughter Catherine M. McCarthy | | | ADDRESS 3216 Rippling Brook Silver Spring, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Disease 5850 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a Arteriosclerotic Cardiovascular Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from _____ Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. | | | TITLE (SPECIFY) Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED 9-21-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sep. 24, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | | | 25b. REGISTRAR'S SIGNATURE John J. Collins | | | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | | | | | |

RECEIVED

NOV 19 1944

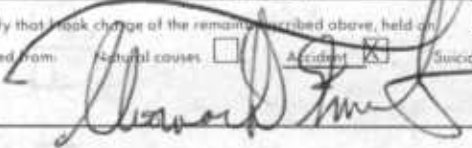
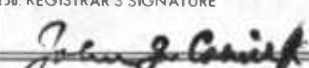


Handwritten signature or name, possibly "Franklin D. Roosevelt".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25178 | |
|---|---------------|--|---|---|--------------------------------|---|--|---|--|----------|--|
| 1. STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Michael McCarthy | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 12 1983 | | 2b. HOUR 10:18 PM | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 8 8 58 | 6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 9 12 1983 | | 2d. HOUR 10:18 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Camp Springs | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Andrews Air Force Base Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Active Duty | | 12b. KIND OF BUSINESS OR INDUSTRY USAF | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY PG | | 13c. CITY OR TOWN Morningside | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Morningside Fire Dept. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel P. McCarthy | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sandra J. McCarthy | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 1979-1983 | | 17. INFORMANT ADDRESS 1307 Rio Linda | | Sandra J. McCarthy; San Antonio, Tx. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8/181 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 9:30 P.M. 9 12 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject fell from fire truck and was run over | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Allentown Rd & Berkshire Dr, Camp Springs, P.G.MD | | | | | |
| 22a. I certify that the change of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER | | | | DATE SIGNED 9/13/83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Removal | | 23b. DATE 9-14-83 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Hill Mortuary | | 23d. LOCATION CITY OR TOWN COUNTY STATE San Antonio, Texas | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MARSHALL FUNERAL HOME Washington, DC | | | | 25a. DATE REC'D. BY REGISTRAR 9/19/83 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |



UNITED STATES
NAVY

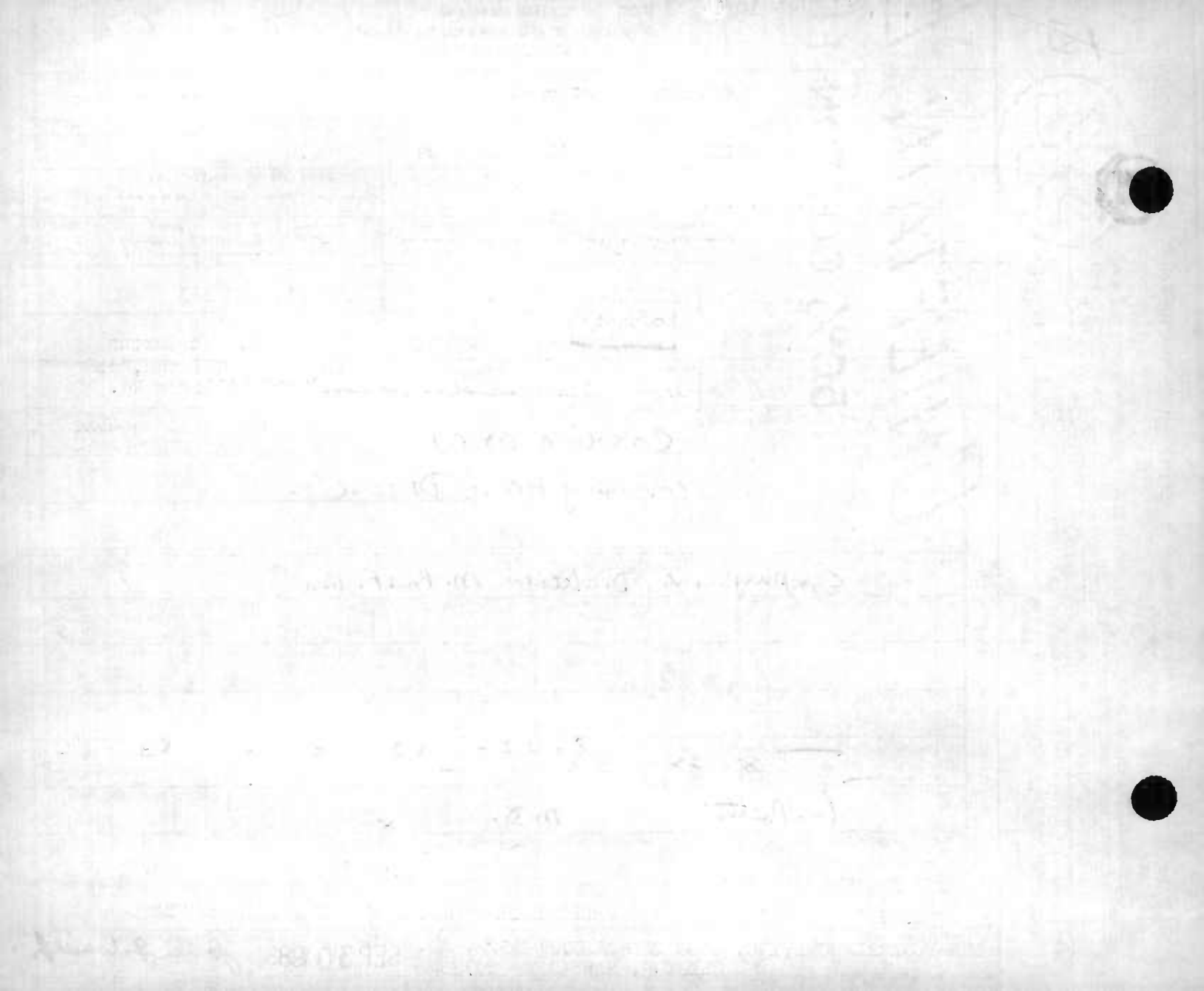
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| #14,17, Film G584 10/6 /83 kam | | | | | | | | | | STATE OF MARYLAND | | 25179 | |
|--|--|--|--|---|--|--|--|--|--|--|--|-------|--|
| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) John Anthony McConaty | | | | | | 2a. DATE OF DEATH MONTH 9 DAY 28 YEAR 83 | | 7b. HOUR 9:55P M | | | | | |
| 3 SEX Male | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 12 DAY 29 YEAR 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH CLINTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSURE FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNION REPRESENTATIVE/ | | 12b. KIND OF BUSINESS OR INDUSTRY AFL-CIO | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY ST. MARY'S 13c. CITY OR TOWN HOLLYWOOD | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS ROUTE #1, BOX 563 20636 | | | | | |
| 14. FATHER'S NAME FIRST THOMAS MIDDLE A. LAST McConaty | | 15. MOTHER'S MAIDEN NAME FIRST LORETTA MIDDLE J. LAST Mc Carten | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A | | 16b. SOCIAL SECURITY NO. 579-03-0322 | | 17. INFORMANT Thomas McConaty, Clinton, Md. 20735 Donnie McConaty, 7305 Milligan Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Emphysema, Diabetes, Malnutrition | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 8-22- 19 83 , to 8-28- 19 83 , that (I) (we) last saw the deceased alive on 8-28- 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 27b. SIGNATURE G.S. Rath | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 27c. DATE SIGNED | | | | | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT) G.S. Rath, MD | | 27e. ADDRESS Charles Profession Center, Waldorf, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 10-1- 83 | | 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY | | 23d. LOCATION CITY OR TOWN CLINTON, MARYLAND STATE | | | | | | | |
| 24. FUNERAL DIRECTOR LEE FUNERAL HOME, INC. 6633 OLD ALEXANDER FR. RD. CLINTON, MARYLAND 20735 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARLENE Dolan MCGINNIS | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 27 83 | | | 2b. HOUR 11:42A _M | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 11-4-1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH CLINTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | |
| 13a. STATE Maryland | | 13b. COUNTY Charles | | 13c. CITY OR TOWN Waldorf | | 13d. STREET ADDRESS 3004-A Pilgrim Square, 20601 | |

| | | | |
|--|--|--|--|
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Dolan | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Flynn | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-01-1440 | |
| 17. INFORMANT June Fleming, Troy, Missouri, 63379 | | ADDRESS Rt. 1, Box 213, Ridge Rd. | |

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|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Days | |
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|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Chronic obstructive lung disease, Hypertension, Diabetes</u> | | | |
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|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November</u> 19 <u>79</u> to <u>September 28</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>September 28</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
|--|--|--|--|--|--|--|--|

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|---|--|--|--|-----------------------------|--|
| 22b. SIGNATURE <u>J. S. Young</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/28/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.S. Young, MD | | 22e. ADDRESS 9401 Indian Head Hwy., Oxon Hill, Md 20021 | | | |

| | | | | | | | |
|--|--|------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-3-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland | |
|--|--|------------------------|--|---|--|--|--|

| | | | | | |
|---|--|---|--|---|--|
| 24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Md. 20601 | | 25a. DATE REC'D. BY REGISTRAR OCT 6 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conish</u> | |
|---|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON

CHIEF-MAN



WATER TOWER, WAINWRIGHT, N.Y. 13080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 25181 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clifford Arvin MC GRIFF SR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 28, 1983 | | 2b. HOUR 5:10am M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 20 1999 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fla. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Univ, Fla. Staff | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STREET ADDRESS 408 EAST Iowa Ave. 99999 | | | |
| 13a. STATE Fla | | 13b. COUNTY | | 13c. CITY OR TOWN Bonifay | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Arvin Mc Griff | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Francis Glovenia Mc Daniel | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> WWI | | | |
| 16b. SOCIAL SECURITY NO. 261-07-3092 | | 17. INFORMANT Dorothy Mc Griff | | ADDRESS 8685 Brae Brook Dr. Lanham Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9. 26. 19 83 to 9. 28. 19 83, that (I) (we) lost saw the deceased alive on 9. 27. 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE V.P. Singh | | DEGREE M.D. | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED 9. 28. 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. P. SINGH | | 22e. ADDRESS 5632 ANNAPOLIS RD BLADENSBURG MD 20710 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 24Sept83 | | 23c. NAME OF CEMETERY OR CREMATORY Bonifay City Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bonifay Fla. | |
| 24. FUNERAL DIRECTOR, NAME Hats Lanham F.H. | | ADDRESS 9013 ANNAPOLIS RD Lanham MD | | 25a. DATE REC'D. BY REGISTRAR OCT 20 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25182 | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Bridget MCLAUGHLIN | | | | 7a. DATE OF DEATH MONTH DAY YEAR 9-17-83 | | | | 2b. HOUR 2:10 PM | | | |
| 3 SEX F | | 4 RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR February 2 1889 | | | | 6 AGE (IN YEARS LAST BIRTHDAY) 94 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY home | | | |
| 13a. STATE Maryland | | 13b. COUNTY Pr. George | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4922 LaSalle Road 20782 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dan Doody | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lane | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 577-84-2377 | | 17. INFORMANT Kathleen M. Russell | | ADDRESS 8526 Wagon Wheel Rd. Alexandria, Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAY | | | |
| 4049 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) ART. SC. CAR. REV. VAS. DIS. YEARS | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CEREBRAL ISCHEMIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/17/83 to 9/17/83 , that (I) (we) lost saw the deceased alive on 9/17/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) see the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Frederick W. Schneider MD | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/17/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK W. SCHNEIDER | | | | 22e. ADDRESS 201-B STONE DC 20002 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/21/83 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer Virginia | | | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home | | | | ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 REGISTRAR'S SIGNATURE John J. Conner | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| FOR 1 - STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MINNIE ADA MC MILLAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-16-83 | | | 2b. HOUR 12:30PM | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 28 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY At home | |
| 13a. STATE Maryland | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN District Hgts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2103 Burgess Place | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter S. Bowman | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Nester | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-20-6260 | | 17. INFORMANT ADDRESS Russell E. McMillan 3541 Patuxent Road Huntingtown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD & Chronic renal failure 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic generalized sepsis, Metabolic DUE TO, OR AS A CONSEQUENCE OF (c) Disorder & Stutter epulphous. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 23, 1983 to Sept 16, 1983 , that (I) (we) lost saw the deceased alive on Sept 16, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert D. Deitz, M.D. | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/17/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert D. Deitz, M.D. | | | | | 22e. ADDRESS 6525 Belcrest Rd., Hattsville, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY Epiphany Episc. Ch. Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Forestville P.G. Maryland | | |
| 24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | |

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PRINCE GEORGE'S GENERAL HOSPITAL

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|---------------------|--|---|---|--|---|---|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Kathryn W Mehalic | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 9 12 83 | | 2b. HOUR 7.25 P.M. | | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR May 24, 1912 | 6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD 9 12 83 | | 7d. HOUR 7.25 P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD | | | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Boydton Beach FL Doctors Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reg. Pract. Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Florida | | | 13c. CITY OR TOWN Boydton Beach | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 327 North East 15th Ave | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leo L. Williamson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Park | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 578-14-8341 | | 17. INFORMANT ADDRESS Michael M. Mehalic, Sr. (Same as #13 above) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) hypertension (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE SAM A. DARRIN | | | TITLE (SPECIFY) M.D. Deputy | | | MEDICAL EXAMINER | | DATE SIGNED 9-12-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) 5632 Annapolis Rd | | | ADDRESS Adelensburg MD 20710 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/16/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Md. | | | | |
| 24. FUNERAL DIRECTOR NAME John J. Cawich | | | | ADDRESS 54 Carroll St. N.W. | | 25. DATE REC'D. BY REGISTRAR SEP 16 1983 | | 26. REGISTRAR'S SIGNATURE John J. Cawich | | | |
| TAKOMA FUN'L HOME, INC. WASH, D.C. 20012 | | | | | | | | | | | |



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U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|----------------------|---|--|--|-----------------------------|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Anne Esther METZGER | | | | | | | 2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 9-8-83 | | 2b. HOUR 10:30 | | |
| 3. SEX female | 4. RACE white | 5. DATE OF BIRTH (MONTH DAY YEAR) Oct. 19 1897 | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 9-8-83 | | 2d. HOUR 10:30 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) washington dc | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. CITY OR COUNTY OF DEATH Prince Georges | | | | | |
| 10. CITY OR TOWN OF DEATH Suitland | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2526 Whitehall St #672 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY n/a | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET ADDRESS 2526 Whitehall St. 20201 | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Suitland | | | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Ferdinand Estler | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. n/a | | 17. INFORMANT Barbara Tucker | | ADDRESS Friendship Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic hyperTensive Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusta H. Langley | | | | MEDICAL EXAMINER (SPECIFY) Deputy | | | | DATE SIGNED 9-8-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Sgt. Royburn | | | | ADDRESS 5009 Royburn Ct. Compagny | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | | 23b. DATE Sept. 10, 1983 | | | | 23c. LOCATION CITY OR TOWN COUNTY STATE Friendship & AA MD | | | |
| 24. FUNERAL DIRECTOR NAME Raasch Funeral Home Owings Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1983 | | | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | | | |

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19-8-83
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Everett D. Milans | | | 2a. DATE OF DEATH MONTH DAY YEAR September 1, 1983 | | 2b. HOUR 6:00P M |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD | |
| 10. CITY OR TOWN OF DEATH College Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4330 Hartwick Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | 12b. KIND OF BUSINESS OR INDUSTRY Education | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | | 13c. COUNTY Prince George | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS (20740) 4330 Hartwick Road #201 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert McPherson Milans | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia E. Willett | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | 17. INFORMANT ADDRESS 1006 Belleview Road Elizabeth M. Dansereau McLean, VA | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Carcinoma of the Tongue</u> 1419 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/9/82</u> 19 <u>82</u> , to <u>8/5</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>8/5/83</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Patrick J. Byrne M.D.</u> | | DEGREE M.D. | | 22c. DATE SIGNED Sept. 2, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick J. Byrne, M.D. | | 22e. ADDRESS 3800 Reservoir Road, N.W. Washington, D.C. 20007 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Sept. 7, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Congressional Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814 | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))

20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25187
~~25106~~

| | | | | | |
|---|------------------|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA JEAN MILLER | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9 8 19 83 | | 2b. HOUR M |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 13 1962 | 6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 8 19 83 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Hillcrest Heights | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3714 Branch Ave. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHARWOMAN | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN PRINCE GEORGE'S SEAT PLEASANT | | 13c. CITY OR TOWN 20743 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAKE ANDREW MILLER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSALEE LEDBETTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 29 2256 | | 17. INFORMANT 510 CARMODY HILLS DRIVE ROSA LEE MILLER SEAT PLEASANT, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blunt force head trauma</u> 9682 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:40x 9-8- 19 83 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject was beaten. | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) Prince George's Motor Lodge | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3714 Branch Ave., Hillcrest Heights, Prince George's Md. | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Assistant | | DATE SIGNED 9-8-83 | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-13-83 | | 23c. NAME OF CEMETERY OR CREMATORY HARMONY PK. | |
| 24. FUNERAL DIRECTOR NAME ROLLINS | | ADDRESS 4339 HUNT PL. N.E. | | 23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER (P.G.) MD. | |
| 25. DATE REC'D. BY REGISTRAR SEP 26 1983 | | 26. REGISTRAR'S SIGNATURE | | | |

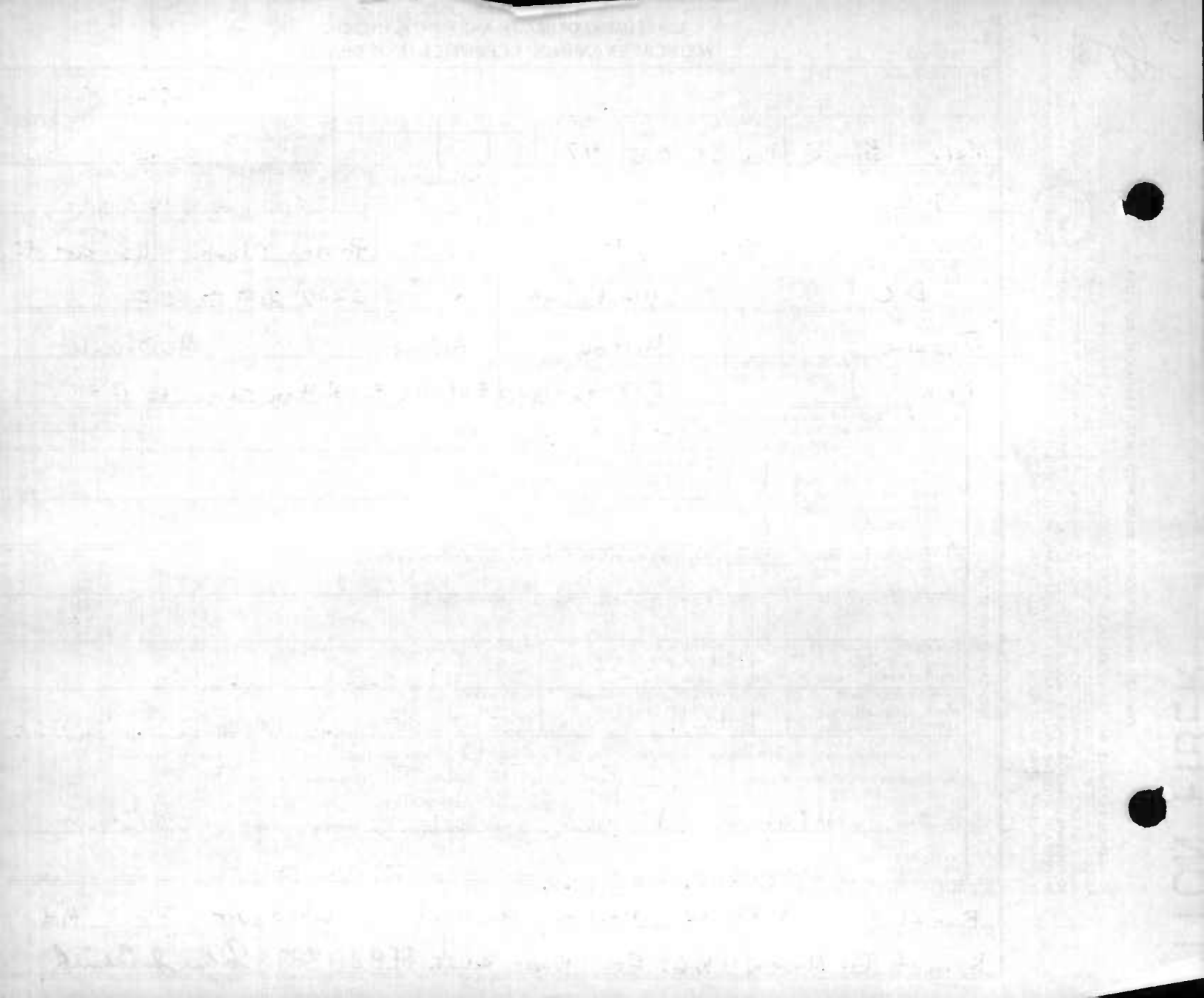
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SEP 28 1983
U.S. GOVERNMENT PRINTING OFFICE
0-13-83

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|----------------------|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) THOMAS L. MILTON | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9-18-83 | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 29 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2b. DATE PRONOUNCED DEAD 9-18-83 19 2AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's County Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Postal Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Post off. | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE D.C. | | | | 13b. COUNTY Washington | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 3207 21st St. S.E. 99999 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jessie Milton | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aleene McDonald | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Army | | | | 16b. SOCIAL SECURITY NO. 578-46-1540 | | | | 17. INFORMANT ADDRESS Estelle E. Milton Same AS 13 E. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple injuries 8147 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY A.M. MONTH DAY YEAR 1AM 9-18-83 P.M. 9-18-83 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) pedestrian struck by an vehicle | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy. | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5300 Sheriffs Rd. Fairmount Hgts., Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margareta Oreghelle | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 9-19-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margareta A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-23-83 | | | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial | | | |
| 24. FUNERAL DIRECTOR NAME Robert G. Mason | | | | ADDRESS Kobel Good Hope Rd. St. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG Md. | | | |
| 25a. DATE REC'D. BY REGISTRAR SEP 20 1983 | | | | 25b. REGISTRAR'S SIGNATURE John J. Canine | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ZOFIA MONKIEWICZ | | | 2a. DATE OF DEATH MONTH 9 DAY 29 YEAR 83 | | | 2b. HOUR 3:00P M | |
| 3 SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH June DAY 8 YEAR 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shoe Maker Retired | |
| 12b. KIND OF BUSINESS OR INDUSTRY Shoe Factory | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince Georges Camp Springs 13c. CITY OR TOWN Clinton | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 5701 Hartwell Street 20748 | |
| 14. FATHER'S NAME FIRST Kostanty MIDDLE Harrasimowicz LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST Jozefa MIDDLE Gruntmeyer LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT Witold B. Monkiewicz ADDRESS 5701 Hartwell Street Camp Springs Md. 20748 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Myocardial Infarction, Hypertension

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION 10/3/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/3/83 to 10/3/83 , that (I) (we) lost saw the deceased alive on 10/3/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Rene Grace | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 10/3/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rene Grace | | 22e. ADDRESS 915 P. St. Clinton, MD | | | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/3/83 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brockton Plymouth Co. Mass. | |
| 24. FUNERAL DIRECTOR Lee Funeral Home Inc. 6633 Old Alexander Ferry Road | | | | 25a. DATE REC'D. BY REGISTRAR OCT 6 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Wm. B. Wood
Clerk of Court

Wm. W. W. W.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17

(VR A15 ME)

20M 4/82

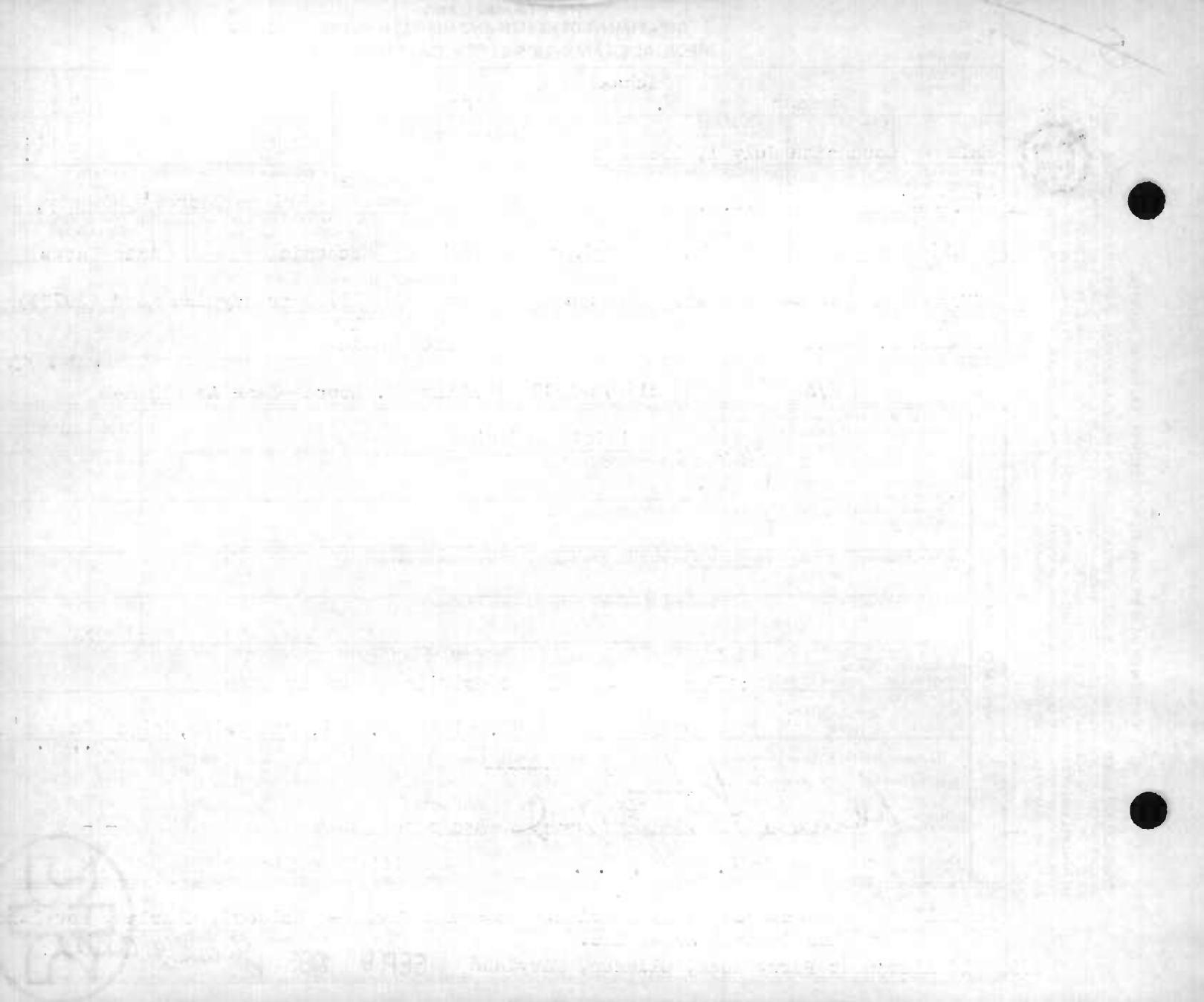
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25190

REG. NO.

| | | | | | | | | |
|--|----------------------|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Joseph MIDDLE: Michael LAST: Moore | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH: 9 DAY: 4 YEAR: 1983 | | | 2b. HOUR 5:39 a.m. | | |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH: July DAY: 1 YEAR: 1964 | 6. AGE (IN YEARS) LAST BIRTHDAY: 19 YRS. | IF UNDER 24 HRS. MONTHS: DAYS: HOURS: MIN. | 2c. DATE PRONOUNCED DEAD MONTH: 9 DAY: 4 YEAR: 1983 | | | 2d. HOUR 5:39 a.m. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY Auto Parts | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Prince George's Clinton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11700 Brandywine Road (20735) | | |
| 14. FATHER'S NAME FIRST: William E. MIDDLE: Moore LAST: Moore | | | | 15. MOTHER'S MAIDEN NAME FIRST: Betty MIDDLE: Daniels LAST: Daniels | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS William E. Moore--Same As #13 A-E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:47 p.m. 9 4 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | 21f. LOCATION STREET: Rt. 301 at Rt. 381, Brandywine, Prince George's Co., Md. CITY OR TOWN: COUNTY: STATE: | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | DATE SIGNED 9-4-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE September 8, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens | | 23d. LOCATION CITY OR TOWN: Waldorf, Charles, Maryland COUNTY: STATE: | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. | | | ADDRESS 1633 Old Alexander Ferry Road, Clinton, Maryland | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Carver |



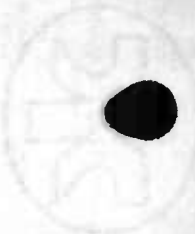
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) SARAH E. MORGAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 12 83 | | | | | 2b. HOUR 12:23A.M. | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | | 8. IF UNDER 74 HRS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk | | 13. KIND OF BUSINESS OR INDUSTRY | | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Upper Marlboro 13c. CITY OR TOWN Upper Marlboro | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6206 Dower Village 20776 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Granvel Stewart | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Carrington | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. 579 14 1967 | | 17. INFORMANT ADDRESS Theodore Morgan-husband | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DIABETES MELLITUS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ACUTE RESPIRATORY FAILURE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-6 , 19 83 , to 9-11 , 19 83 , that (I) (we) lost saw the deceased alive on 9-11-1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE R.B. Samtani | | | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-13-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJ. SAMTANI | | | | | 22e. ADDRESS 9015 WOODYARD RD CLINTON MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept. 15, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cheltenham Veterans Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Md. | | | |
| 24. FUNERAL DIRECTOR NAME John T. Stewart | | | | | 25. DATE REC'D. BY REGISTRAR SEP 22 1983 | | | | | | |
| Stewart Funeral Home-4001 Benning Road, Baltimore, Md. | | | | | | | | | | | |

BP _____



10/11

Stewart Funeral Home - 101 Spring Road, N.E.

Sept. 12, 1983, Chester Veterans Cemetery

Chiltenham, N.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25192

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE ESTIMATED | | 2d. HOUR | |
| Sarah M. Morrison | | Sept. 28, 83 | | 6:50 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE IN YEARS | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| Female | White | June 25, 1892 | 91 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 1. MARRIED | | 2. NEVER MARRIED | |
| Virginia | U.S.A. | WIDOWED <input checked="" type="checkbox"/> | | DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Adelphi | 2206 Phelps Rd. # 108 (20783) | Homemaker | | Home | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | P.G. Co., | Adelphi | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2206 Phelps Rd. # 108 (20783) | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | | | |
| Ruppert | Brightwell | Betty Lumsden | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | |
| Yes | WWI | Annette Chapman 14012 Oakvale St. Rockville Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Said A. Daee | | Deputy | | Sept/29/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Dr. Said Daee | | 5632 Annapolis Rd. Bladensburg, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Cremation | Sept/29/83 | Cedar Hill Crematory | | Suitland, P.G. Co., Maryland | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Chambers Funeral Home | | OCT 03 1983 | | John J. Carver | |

RECEIVED
JUN 10 1964

U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | REG. NO. | |
|--|--|------------------|--|---|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|----------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GARY A. MOTTLEY | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9-8-83 19 | | | | 2b. HOUR M | | | | | | | |
| 3. SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 4 63 | | 6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-8-83 19 | | | | 2d. HOUR 8:45 PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Trinidad | | | | 7b. CITIZEN OF WHAT COUNTRY? Trinidad | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Co. Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Active Duty | | | | 12b. KIND OF BUSINESS OR INDUSTRY US Navy | | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | | 13b. COUNTY Prince Geor | | | | 13c. CITY OR TOWN Ft. Washing | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3102 Lumar Dr 20744 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carl Noel | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Andrea Mottley | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 1/81-9/83 | | 17. INFORMANT Andrea M. Telesford/3102 Lumar Dr | | | | 17b. ADDRESS Ft. Washington, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8121 Cranio-cerebral injury DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 7:40 PM 9-8-83 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in an auto in collision with a fire ladder truck | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5500 blk. Marlboro Pike District Hgts., Md. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | TITLE (SPECIFY) Assistant | | DATE SIGNED 9-9-83 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | | | | | | | ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-13-83 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Marshall Funeral Home | | | | | | | | | | ADDRESS 4217 9th St., NW | | 25. DATE REC'D. BY REGISTRAR SEP 15 1983 | | 26. REGISTRAR'S SIGNATURE <i>John J. Connel</i> | | | | | | | |

BP

MEMORANDUM FOR THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]



SEP 1 1950

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25194

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|----------------------------|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Raymond I. Mummert | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 9 DAY 9 YEAR 1983 | | 2b. HOUR 4:34 M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH Dec. DAY 12 YEAR 1901 | 6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Sales Rep. | 12b. KIND OF BUSINESS OR INDUSTRY Sears |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Maryland | 13b. COUNTY P.G. | 13c. CITY OR TOWN Cheverly | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS Zip Code - 20785 5812 Greenleaf Road | |
| 14. FATHER'S NAME FIRST David MIDDLE LAST Mummert | | | 15. MOTHER'S MAIDEN NAME FIRST Kate MIDDLE LAST Strausbaugh | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 176-06-9513 | | 17. INFORMANT ADDRESS Mrs. Martha B. Mummert No# 13e. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4148 Angiocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE SAID A. DAE | | TITLE (SPECIFY) Dep. | | DATE SIGNED Sept. 10, 1983 | |
| EXAMINER'S NAME (TYPE OR PRINT) Said A. Dae, M.D. | | ADDRESS 5632 Annapolis Road, Suite #10 Bladensburg, Maryland 20710 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 12, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | 23d. LOCATION CITY OR TOWN Brentwood COUNTY P.G. STATE Maryland |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. ADDRESS Hyattsville, Maryland | | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHW: - 10 50M 1-111
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| Dorothy Nash | | 9 10 83 | | 6 10 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| F | Black | MONTH DAY YEAR | 58 | Prince Georges County MD. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. CITIZEN OF WHAT COUNTRY? | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Washington DC | USA | Prince Georges County MD. | | | |
| 12. CITY OR TOWN OF DEATH | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Forestville Md | Regency N.H. 7420 Marlboro Pike | | Food Service | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 16. STATE | 17. CITY OR TOWN | 18. INSIDE CITY LIMITS? | | |
| District of Columbia | DC | Washington | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 19. FATHER'S NAME | 20. MOTHER'S MAIDEN NAME | | 21. STREET ADDRESS | | |
| Oscar McCommon | Alberta Sparks | | 612 E Street, N.E. 99999 | | |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 23. SOCIAL SECURITY NO. | 24. MARRIAGE ADDRESS | | | |
| NO | 288 22 0650 | Mrs. Victoria Harrison-sister-435 East 57th Street, Brooklyn, New York | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1950 Respiratory Arrest | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) Cancer, Head & Neck | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15/83 to 9/10/83, that (I) (we) lost saw the deceased alive on 9/10/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Robert M. Applewhite MD. | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| ROBERT M. APPLEWHITE | | 5100 Auth Way, Suitland, MD 20746 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Cremation | Sept. 19, 1983 | Lee's Crematorium | Washington | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | |
| Stewart | | SEP 22 1983 | | | |
| Funeral Home-4001 Benning Rd. | | John T. Stewart | | | |

MEDICAL CERTIFICATION

47

29

999999

U.S. GOVERNMENT PRINTING OFFICE

U.S. GOVERNMENT PRINTING OFFICE

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U.S. GOVERNMENT PRINTING OFFICE

U.S. GOVERNMENT PRINTING OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) BEULAH H. MAE NECLOS | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 18 83 | | | 2b. HOUR 11 05PM | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 8-3-1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (PRINCE GEORGE GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Charwoman | | 12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY P.G.C. | | 13c. CITY OR TOWN MT. RANIER | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3225 R.I. AVE 20712 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EDWARD COCHRAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA STEELE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN | | 17. INFORMANT ADDRESS VERONICA FOSTER 3225 R.I. AVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest.</u> <u>5990</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>recurrent urinary tract infection and</u> (c) <u>Bactera Sepsis.</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Left CVA with Aphasia J-hypertension.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-8</u> , 19 <u>83</u> , to <u>9-18</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9-18</u> , 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>R. Arora</u> | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/19/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. ARORA M.D. | | | | 22e. ADDRESS 14300 GALLANT FOX LANE BOWIE, MD. 20715 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9-23-83 | | 23c. NAME OF CEMETERY OR CREMATORY George wash. cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi PGC Maryland | | | |
| 24. FUNERAL DIRECTOR NAME MODERN FUNERAL | | | | ADDRESS 3821 14th ST NW | | 25a. DATE REC'D. BY REGISTRAR SEP 23 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John L. Gail</u> | |

BP

12 83 11 25

RECLOS

GENUINE

PRINCE GEORGE COUNTY

PRINCE GEORGE GENERAL HOSPITAL

CHEVERLY



FILED IN

IN THE COUNTY OF PRINCE GEORGE

W. ARORA M.D.

GEORGE WASH. UNIVERSITY

1983 APR 23

1983 APR 23

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Patricia Jean Nelson | | | 2a. DATE OF DEATH MONTH DAY YEAR September 13 1983 | | 2b. HOUR M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR May 24 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD | |
| 10. CITY OR TOWN OF DEATH Temple Hills | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5715 Joan Lane | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector | 12b. KIND OF BUSINESS OR INDUSTRY Movie Ind. | |
| 13a. STATE Maryland | | | 13b. COUNTY Pr Geo | 13c. CITY OR TOWN Temple Hills | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick Atkinson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Shipley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 578 36 6682 | | 17. INFORMANT ADDRESS William A Nelson Same as #13 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis

1749

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

Adenocarcinoma of breast

DUE TO, OR AS A CONSEQUENCE OF

(c)


APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

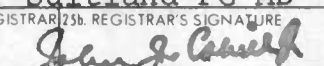
1 year

8 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

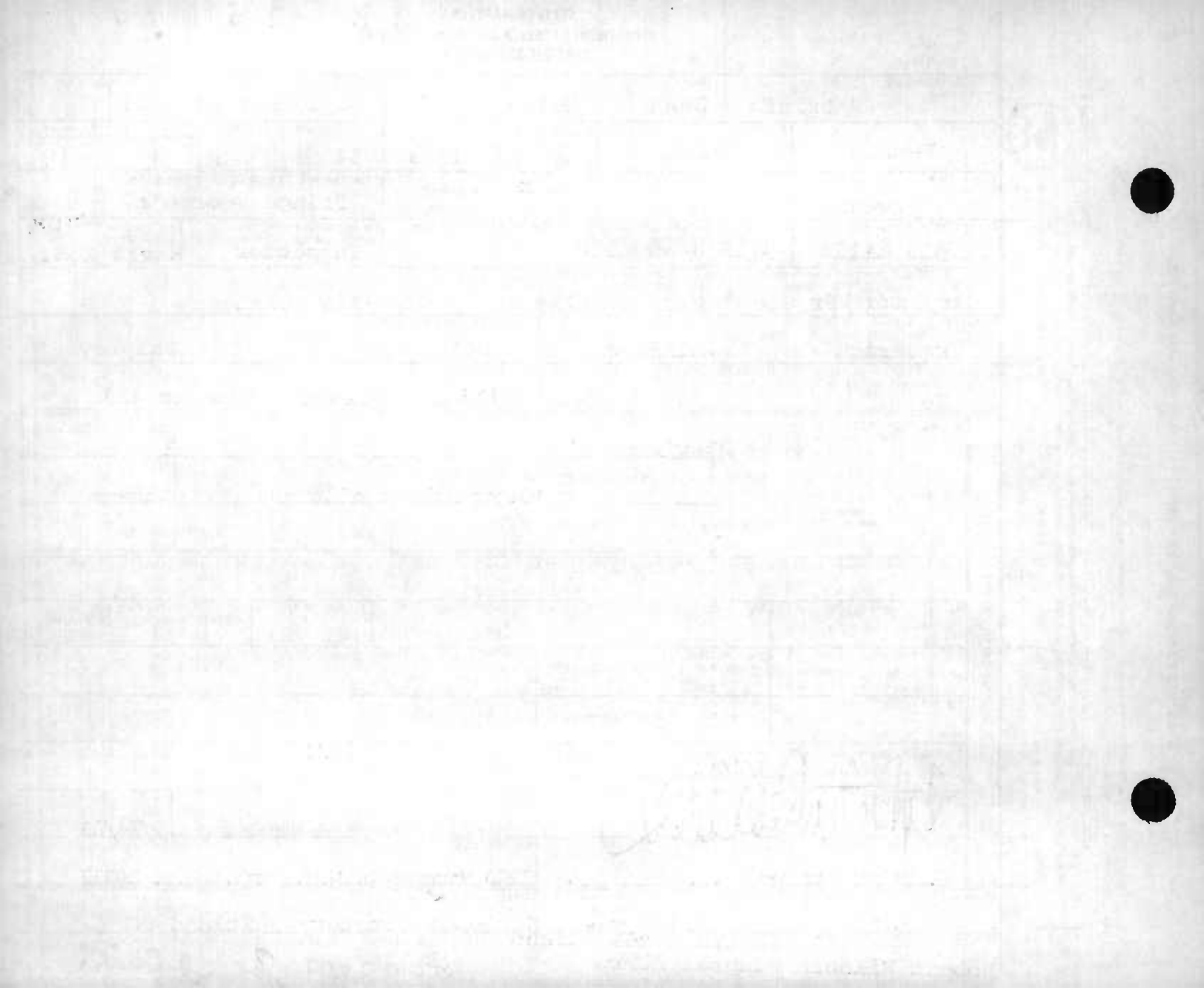
| | | | | | |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/8</u> , 19 <u>80</u> , to <u>9/8</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/8/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I signed and did not view the body after death.) | | | | | |
| 22b. SIGNATURE  | | | | 22c. DATE SIGNED 9/14/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Peter Pushkas, M.D. | | | | 22e. ADDRESS 1140 Varnum St. N.E. Wash., D.C. 20017 | |

| | | | |
|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 9/16/83 | 23c. NAME OF CEMETERY OR CREMATORY Wash. National Cemetery Suitland PG MD | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| 24. FUNERAL DIRECTOR NAME Robert Wilhelm Funeral Home | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE  | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST Veatrice M. Nobles | | | | September 18, 1983 12:35AM | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Jessup | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Martin Nobles | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Easter Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-01-2582 | | 17. INFORMANT ADDRESS Mary L. Nash (Daughter) Jessup, Md. 20794 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4360</u> <u>CELEBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CELEBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CELEBROVASCULAR ACCIDENT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> , 19 <u>83</u> , to <u>9/18</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE GREGORY A. COMPTON MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9-18-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature] | | | | 22e. ADDRESS 14201 LAUREL PARK DR #104 LAUREL MD 20707 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-22-83 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Md. | |
| 24. FUNERAL DIRECTOR NAME George R. Snowden | | | | 24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850 | | 25. DATE REC'D. BY REGISTRAR SEP 22 1983 | |
| | | | | 26. REGISTRAR'S SIGNATURE [Signature] | | | |

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UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY



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1913 S 3 1883

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|---|---|---|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST JOAN | MIDDLE E. | LAST O'DONOGHUE | MONTH DAY YEAR 9-14-83 | | | 8:05PM M | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 23, 1932 | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress | | | 12b. KIND OF BUSINESS OR INDUSTRY Restaurant | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Prince Geo. | | | 13c. CITY OR TOWN Hyattsville | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph S. Arena | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Dittenhafer | | | 13d. STREET ADDRESS 4009 Gallatin Street 20781 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 38 7041 | | 17. INFORMANT 1820 Daffwood Circle John J. Barnett Oldsmar, Florida 33557 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatorenal failure</u> 5712 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic ETOH abuse</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week Years Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Cardiomyopathy, Asides</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> , 19 <u>83</u> , to <u>9/14</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/14</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Andrew Krinsky</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 9/15/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW KRINSKY | | | | 22e. ADDRESS P6614 CHEVERLY, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial | | 23b. DATE 9/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | | |
| 24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D BY REGISTRAR SEP 19 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Barnett</u> | | |

BP



| | | | | |
|--------------|----------------------------------|-----------|------------------------|---------|
| JOHN | ED | 0-10-1918 | 0-14-23 | 1-10-24 |
| Township | White | ... | ... | ... |
| Pennsylvania | ... | ... | PRINCE GEORGE'S COUNTY | ... |
| CEVERLY | PRINCE GEORGE'S GENERAL HOSPITAL | ... | ... | ... |
| ... | ... | ... | ... | ... |
| ... | ... | ... | ... | ... |
| ... | ... | ... | ... | ... |
| ... | ... | ... | ... | ... |
| ... | ... | ... | ... | ... |
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| ... | ... | ... | ... | ... |



[Faint, illegible handwritten text and signatures across the bottom half of the page.]

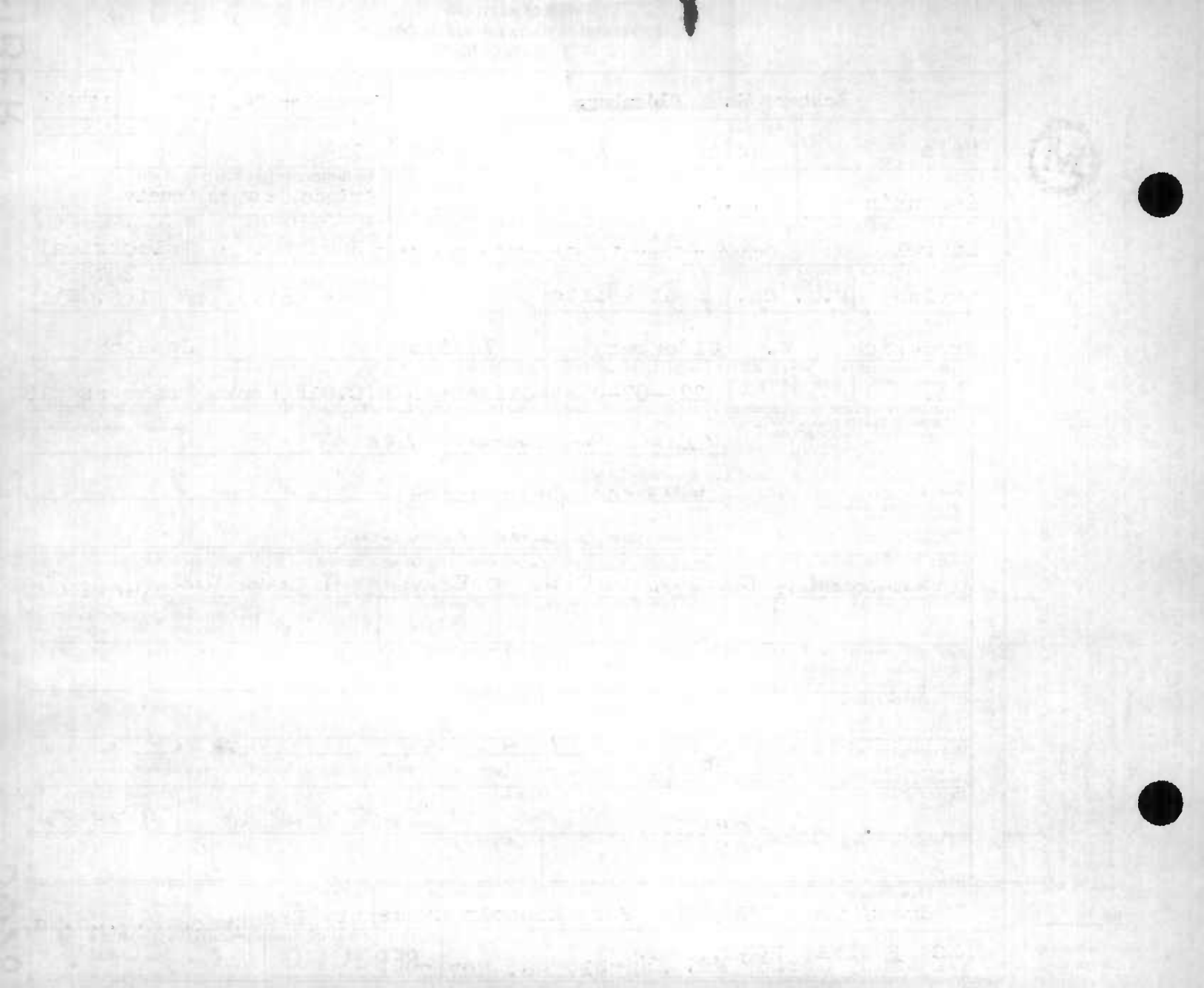
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|--|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Lester W. Oldenburg | | | 2a. DATE OF DEATH MONTH DAY YEAR September 29, 1983 | | 2b. HOUR 11:40A _{AM} | |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR April 14, 1905 | | 6 AGE (IN YEARS (LAST BIRTHDAY)) 78 | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | |
| 10. CITY OR TOWN OF DEATH Laurel | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | |
| 13a. STATE Maryland | | | 13b. COUNTY P.G. Co. | 13c. CITY OR TOWN Beltsville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick W. Oldenburg | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Jenson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO. 229-07-0355 | | 17. INFORMANT ADDRESS Elizabeth E.C. Oldenburg same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Arteriosclerosis</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Uncontrolled Diabetes Mellitus @. Recurrent colon malignancy</u> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-4-83</u> to <u>9-29-83</u> , that (I) (we) last saw the deceased alive on <u>9-28-83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | DEGREE | | 22c. DATE SIGNED <u>9-29-83</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/30/83 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Co. Md. |
| 24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1983 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25201 REG. NO. | |
|--|--|--------------|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Leon O'Pry, Jr. | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9 5 1983 | | 2b. HOUR M 9A | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 6/16/30 | | 6. AGE (IN YEARS) LAST BIRTHDAY 53 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 5 1983 | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD | | |
| 10. CITY OR TOWN OF DEATH Suitland | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3814 Regency Parkway | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Consultant - Civil Service | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE GA | | | 13b. COUNTY Muscogee | | 13c. CITY OR TOWN Columbus | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 601 24th St., 31907 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert L. O'Pry, Sr. | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Brannon | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT Mrs. Lillian O'Pry, | | | ADDRESS Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | 20. AUTOPSY? BODY ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | 22b. Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| ACTUAL SIGNATURE Thomas D. Smith, M.D. | | | TITLE (SPECIFY) Deputy Chief | | | | | MEDICAL EXAMINER | | DATE SIGNED 9/5/83 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE 9/8/83 | | 23c. NAME OF CEMETERY OR CREMATORY Riverdale | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Columbus, GA | | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1983 | | | | | |
| REGISTRAR'S SIGNATURE John J. Conner | | | | | | | | | | | |



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | |
|---|---|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Mary E. Orton | | | 2a. DATE OF DEATH MONTH DAY YEAR September 11 1983 | | 2b. HOUR 1:15 AM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR January 13 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S. | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | |
| 10. CITY OR TOWN OF DEATH Panham, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Garden | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN Berwyn Heights | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 6013 Pontine Street Zip Code - 20740 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John H. Waple | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Bean | | ADDRESS Address Same as No# 13e. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 578-03-6035 | | 17. INFORMANT Miss June M. Orton | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5860

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 Sept. 1983 to 11 Sept. 1983 , that (I) (we) lost saw the deceased alive on 9 Sept. 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | |
| 22b. SIGNATURE William A. Wimsatt MD | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 9-11-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William A. Wimsatt, M.D. | | 22e. ADDRESS 8150 Lakecrest Drive - Greenbelt, Maryland | |

| | | | |
|---|------------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Sept. 14, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland |
| 24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 15 1983 John J. Cahill | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Salvatore (N.M.I.) Pace | | | MONTH DAY YEAR 09-29-83 | | 7:32PM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 19, 1899 | 6. AGE (IN YEARS (LAST BIRTHDAY)) 84 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stone Mason | 12b. KIND OF BUSINESS OR INDUSTRY Self-Employed | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. CITY OR TOWN P.G. | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 3802 Coopers Lane 20784 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Francesco Pace | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vincenza Fazio | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. 577-14-0978 | 17. INFORMANT Mrs. Alda C. Pace | | ADDRESS Address Same as No# 13e. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION (c) ANOXIC ENCEPHALOPATHY | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) PNEUMONITIS OF RIGHT LUNG | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5.15. 19.83 , to 9.29. 19.83 , that (I) (we) last saw the deceased alive on 9.29. 19.83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE V.P. Singh | DEGREE MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9.30.83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.P. SINGH | | 22e. ADDRESS 5632 ANNAPOLIS RD BLADENSBURG MD. 20710 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Oct. 3, 1983 | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland | | DATE RECEIVED BY REGISTRAR OCT 6 1983 REGISTRAR'S SIGNATURE John J. Gough | | | | |

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CHEN, Y. L.

PRINCE GEORGE'S CENTRAL HOTEL

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Oct. 2, 1964. St. Mary's Cemetery. Washington, D.C.

700-268-9000

2.1. *not in use*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | 2. DATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | MONTH DAY YEAR | | 28 HOUR | | | |
| TED TARKINGTON PARKE | | | | 9/30/83 | | 12 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | WHITE | | OCT. 19, 1913 ^{AR} | | 69 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Illinois | | U.S.A. | | | | PRINCE GEORGES MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (IF WORK OR MOST RECENTLY) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| RIVERDALE | | LELAND MEMORIAL HOSPITAL | | Ret. Truck Driver | | Oil Co. | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Prince Geo. | | Hyattsville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4708 40 th Avenue 20781 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| Newton C. Parke | | Julia McLeod | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 577 03 2545A | | Emma Jane Parke Same as #13 (Wife) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYO CARDIAL INFARCTION</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>GASTRO INTESTINAL BLEEDING</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| Roger B. Ingham, M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 10-2-83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Roger B. Ingham, M.D. | | 5701 85 th Ave. New Carrollton, Md. 20784 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 10/4/83 | | Ft. Lincoln Cemetery | | Brentwood P.G. COUNTY Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | OCT 4 1983 | | James J. Smith | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25205 | | | |
|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST Barbara Dancel Pecson | | | | September 7, 1983 | | | |
| 3. SEX Female | | 4. RACE Filipino | | 5. DATE OF BIRTH MONTH DAY YEAR 6 27 55 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 28 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hawaii | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Amer. Legion | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN Upper Marlboro | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 221 Harry S. Truman Dr. 20772 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Roberto Dancel | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rozela Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 576-68-9715 | | 17. INFORMANT ADDRESS Benjamin M. Pecson same as item 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1749 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours 6 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE STREET | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 6, 1983 to Sept 7, 1983 , that (I) (we) last saw the deceased alive on Sept 7, 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Thomas A. Beusinger | | | | DEGREE MD | | 22c. DATE SIGNED 9/7/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. BEUSINGER, MD | | | | 22e. ADDRESS 7676 New Hampshire Ave Langley Park MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/12/83 | | 23c. NAME OF CEMETERY OR CREMATORY Hawaiian Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY Kaneoke Hawaii | |
| 24. FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | 25b. REGISTRAR'S SIGNATURE James G. Gair | |

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Let μ and ν be measures on \mathcal{X} and \mathcal{Y} respectively. Let f be a function on \mathcal{X} and g be a function on \mathcal{Y} . Then the product measure $\mu \otimes \nu$ is defined by

2000

STROS, M. HANDEL, P. YVES, 195

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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7. *Environ. Sci. Technol.* 1991, 25, 1035-1040.

55019

173

John A. Smith

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 5 2 0 6

REG. NO.

| | | | | | | | | |
|--|--|--|---|---|--------------------------------------|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| RICHARD PERLICH | | | SEPTEMBER 25, 1983 | | | 0920aM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| MALE | CAUCASION | SEPTEMBER 28, 1920 | 62 | | | MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MINNESOTA | UNITED STATES | | | | PRINCE GEORGE'S COUNTY MD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ANDREWS AFB | MALCOLM GROW USAF MEDICAL CENTER | | | MILITARY | | | USAF | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | 22101 | |
| VIRGINIA | FAIRFAX | MCCLEAN | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 6613 OLD CHESTERBROOK ROAD | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | ADDRESS | | |
| RUDOLPH PERLICH | | | ROSE | | | old POLSKI | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| YES | | | 469-16-7000 | | | ELIZABETH PERLICH | | |
| | | | | | | MCCLEAN, VA 22101 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4275 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 22 Aug 1983, to 25 Sept 1983, that (I) (we) lost saw the deceased alive on 25 Sept 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED |
| Kathryn Amacher DO | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 25 Sept 83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | |
| KATHYRN AMACHER | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Removal | | | 9/26/83 | | | | CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| NAME | | | | | | OCT 3 1983 | | John J. Carver |
| Anatomy Board | | | | | | Balto., Md. | | |

• 501 • 03/2007

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED AS SOON AS POSSIBLE. TO EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25207

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

Augustine

Pinkney

2a. DATE KNOWN OF DEATH ESTIMATED
MONTH DAY YEAR
9 10 1983
2b. HOUR
7A

3. SEX

R

4. RACE

B

5. DATE OF BIRTH
MONTH DAY YEAR
Feb 20 19396. AGE (IN YEARS
LAST BIRTHDAY)
44 YRS.IF UNDER 1 YR.
MONTHS DAYSIF UNDER 24 HRS.
HOURS MIN.2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
9 10 1983
2d. HOUR
2A

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George

MD.

10. CITY OR TOWN OF DEATH

Suitland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

2303 Lakewood St.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Security Guard

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Prince George

13c. CITY OR TOWN

Suitland

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

2303 Lakewood St.

20746

14. FATHER'S NAME

FIRST

James

MIDDLE

H.

LAST

Johnson Sr.

15. MOTHER'S MAIDEN NAME

FIRST

Mary

MIDDLE

LAST

Gross

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Suitland, Md

Page Pinkney 2303 Lakewood St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4280

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

Asthma

Congestive heart disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

SAID A. DARRIN

M.D.

Deputy

MEDICAL EXAMINER

DATE SIGNED

9-10-83

EXAMINER'S NAME
(TYPE OR PRINT)

5632 Annapolis Rd

ADDRESS

Bridensbury MD 20710

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Sept. 14-83

23c. NAME OF CEMETERY OR CREMATORY

St. Edmonds Chr. Cem

23d. LOCATION
CITY OR TOWN

Sunderland

COUNTY

Calvert

STATE

Md.

24. FUNERAL DIRECTOR
NAME

Spencer E. Sewell

ADDRESS

Box 31, Prince Frederick, Md

25. DATE REC'D. BY REGISTRAR

SEP 15 1983

26. REGISTRAR'S SIGNATURE

Spencer E. Sewell

Feb 20 1973

Prince George

USA

Norfolk

Security Guard

230 Lakewood St.

Norfolk Prince George District

James

Johnson St.

Army

Grass

Large Highway 230 Lakewood St.

no

Butler

Sept 14-73 230 Lakewood St. Prince George

Spencer L. Sewell Box 11 Prince George

SEP 14 1973

Prince George

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY A. PLATER | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-24 83 | | | 2b. HOUR 7:50a.m. | | | |
| 3. SEX M Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 1-6-1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH CLINTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 13a. STATE Md | | | 13b. COUNTY P.G | | 13c. CITY OR TOWN Brandywine | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Toye | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Estep | | | 13e. STREET ADDRESS Rt. 1 Box 15515 Brandywine | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 578-26-4675 | | 17. INFORMANT P.O. Box 54 A Mary A. Young, Bryantown Md 20617 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE CARDIOPULMONARY ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
HOURS

4140
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) ATHEROSCLEROTIC CORONARY HEART DISEASE

YEARS

DUE TO, OR AS A CONSEQUENCE OF
(c) PULMONARY INFILTRATE

DAYS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MASSIVE ISCHEMIC STROKE WITH LEFT HEMIPARESIS, CARDIOMEGALY AND CARDIAC

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. MEDICAL FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from 9-23 83, to 9-24 83, that (I) (we) lost
saw the deceased alive on 9-24 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

| | | | |
|--|--|---|--|
| 22b. SIGNATURE PETER W. YIM M.D. | | 22c. DATE SIGNED 9-24 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER W. YIM M.D. | | 22e. ADDRESS 7900 OLD BRANCH AVE. CLINTON, MD. 20735 | |

| | | | | | | | |
|--|--|----------------------|--|--|--|---------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/28/83 | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection | | 23d. LOCATION CLINTON P.G MD | |
|--|--|----------------------|--|--|--|---------------------------------|--|

| | | | | | |
|---|--|---|--|--|--|
| 24. FUNERAL DIRECTOR NAME Martell Adams, Aquasco Md 20608 | | 25a. DATE REC'D. BY REGISTRAR OCT 5 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | |
|---|--|---|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Harrell Adams, Address No 2008

EX-113 Registration

Clinch

F.C.

18

COX COLON

66

SW-25-102 A

and J. Jones, Addressed No 2007

John

Toy

118

1200

P.O. Box 24

RE-1 Box 1815 Brandywine

P.O.

Brandywine

2

Domestic

Harrell

J. W. A.

2

1-6-1928

69

Harrell

Harrell

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--------------|--|---|--|---|--|---|--|---|--|---|--|--|--|---|--|---|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mary NMI Pleasant | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 9 12 1983 2:18 PM PRONOUNCED DEAD <input type="checkbox"/> 9 12 1983 2:42 PM | | | | | | | | | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 11 15 1970 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 70 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 12 1983 | | 7d. HOUR 2:42 PM | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH P. J. Co. | | | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1001 Chillum Rd Apt 314 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Empl | | | | 12b. KIND OF BUSINESS OR INDUSTRY School | | | | | | | | | |
| 13a. STATE Virginia | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN Richmond | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 108 Liberty Avenue 999999 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Hubbard | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Green | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 223-01-8674 | | | | 17. INFORMANT Hazel L. White; 108 Liberty Ave/ | | | | | |
| 16c. ADDRESS Richmond, Va. | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Said A. Daee | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 9/13/83 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Said A. Daee, M.D. | | | | ADDRESS 5632 Annapolis Rd. #10 Bladensburg Md | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-17-83 | | | | 23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Richmond, Va. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Marshall Funeral Home, Washington, D.C. | | | | ADDRESS 4217 9th St NW | | | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | | | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535



SEP 10 1983
FBI - NEW YORK

SEP 10 1983
FBI - NEW YORK

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 5 FOR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25210 | |
|---|--|----------------------------|--|---|---|---|---|--|---|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Etta Mae POORE | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 9-10-83 | | 2b. HOUR 11:45 | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6-21-16 | | 6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-10-83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County Md. | | |
| 10. CITY OR TOWN OF DEATH Temple Hills | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2600 Keating Street 409 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary-D.C. Government | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Temple Hill | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2600 Keating St. #409 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Cook | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Hoyer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 578-54-8872 | | 17. INFORMANT Temple Hill, Md. 20748 #409 Denise E. Creel-daughter 2600 Keating St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | DATE SIGNED 9-10-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 14 Sept 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Colmar Manor, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Canfield | | | |

Temple Hills 2500/keeping 21st Nov

General Agent for the State of New York

August 1862

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Anthony Costello Potts | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 9 1983 | | 2b. HOUR 4:05pm |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR June 23, 1946 | | 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD. | |
| 10. CITY OR TOWN OF DEATH Hyattsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7422 Jefferson Street | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY Metro | |
| 13a. STATE Maryland | 13b. COUNTY Pr. Geo. | 13c. CITY OR TOWN Hyattsville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 7422 Jefferson Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward - Potts | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy - Brooks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-42-0877 | | 17. INFORMANT ADDRESS Edward Potts (Father) Same as # 13. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the Lung (3-82) 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION March 1982 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer, Right Lung | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) XXXXX | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the Registrar) attended the deceased from August 30 , 19 83 , to Sept. 9 , 19 83 , that (I) XX lost saw the deceased alive on Sept. 5 , 19 83 , and that in (my) XX opinion death occurred on the date and hour and from the causes stated above, (I) XX (did) XXXX view the body after death. | | | | | |
| 22b. SIGNATURE Albert E. Rolle, M.D. | | | | 22c. DATE SIGNED Sept. 9, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert E. Rolle, M.D. | | 22e. ADDRESS 1140 Varnum St., N.E., Washington, D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/13/83 | 23c. NAME OF CEMETERY OR CREMATORY MARYLAND NATIONAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL P.G. MD. |
| 24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. | | ADDRESS 1120 CONN. AVE., N.W. #940 WASHINGTON, D.C. 20036 | | 25a. DATE REC'D. BY REGISTRAR SEP 15 1983 | |
| 25b. REGISTRAR'S SIGNATURE John J. Gough | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

Handwritten notes and tables on lined paper. The text is mostly illegible due to fading and bleed-through. Some visible fragments include:

Top section: *Handwritten notes, possibly a title or header.*

Middle section: *Table with multiple columns and rows of data. Some legible fragments include:*

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|-----|-----|-----|-----|
| ... | ... | ... | ... |
| ... | ... | ... | ... |
| ... | ... | ... | ... |
| ... | ... | ... | ... |

Bottom section: *Handwritten notes and a signature.*

Bottom right: *Handwritten signature, possibly "J. B. Smith".*



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25212

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOHN H. QUEEN | | | 2a. DATE OF DEATH MONTH 09 DAY 25 YEAR 83 | | | 2b. HOUR 11:00A M | | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH Jan. DAY 1. YEAR 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | | 12b. KIND OF BUSINESS OR INDUSTRY None | | |
| 13a. STATE Md. | | | 13b. COUNTY P.G. Landover | | 13c. CITY OR TOWN P. O. Box 1391 | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME FIRST John MIDDLE T. LAST Queen | | | | 15. MOTHER'S MAIDEN NAME FIRST Agnes MIDDLE LAST Savoy | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II | | | |
| 16b. SOCIAL SECURITY NO. 213-16-2658 | | | | 17. INFORMANT 2006 Virginia Ave. | | | | 17. ADDRESS George A. Queen Landover, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/9/83 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED To maintain patent airway | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/23 , 19 83 , to 9/25 , 19 83 , that (I) (we) lost saw the deceased alive on 9/25 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE L. Martynes, M.D. | | | | DEGREE 3rd yr Resident ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 9/28/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Martynes | | | | 22e. ADDRESS P.G.G. H Cheverly Md 20785 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9/29/83 | | 23c. NAME OF (CEMETERY) OR CREMATORY Cheltenham Vet's. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, P.G., Md. | | | |
| 24. FUNERAL DIRECTOR NAME H. S. WASHINGTON + SONS ADDRESS 4925 BURROUGHS AVE., N.E. | | | | | | | | | | | |
| 25. DATE REC'D. BY REGISTRAR OCT 03 1983 REGISTRAR'S SIGNATURE John J. Carver | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25213

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|--------------------------------------|--|---|--|--------------------------------|--|--|--|-----|--|------|--|------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTI- MATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| M. Margaret | | Ranahan | | | | | | 9 | | 25 | | 19 | | 83 | | 145 | | AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| F | W | 6 15 1890 | | 93 YRS. | | | | | | 9 | | 25 | | 19 | | 83 | | 1.45 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Illinois | | U.S.A. | | | | Prince George MD. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | | | | | | |
| Hyattsville | | Sacret heart home | | | | | | | | | | | | | | | | | |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12c. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| None | | None | | Soc. Sec. Admin. S. Govt. | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | | | | | |
| None | | Washington D.C. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1710 Mass. Ave., N.W. 99999 | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Frank | | | | Evelyn | | | | Wright | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | |
| no | | | | 577-58-0921 | | | | M. Jean Whittingham, / | | | | 11 Woodmill Rd. Chappaqua, N.Y. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 20. AUTOPSY? | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE | | | | SIGNED | | | | | | | |
| SAID A. DARRIN | | | | M.D. Deputy | | | | 9-26-83 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| 563 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| BURIAL | | | | 9-28-83 | | | | Calvary Cemetery | | | | Terre Haute Indiana | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Robert A. DeVol | | | | 28 SEP 1983 | | | | J. J. Connel | | | | | | | | | | | |
| ADDRESS | | | | | | | | | | | | | | | | | | | |
| Washington D.C. | | | | | | | | | | | | | | | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25214 | | |
|--|--|------------------|-----------------------|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) Russell P. Rankin | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 9 14 19 83 | | 2b. HOUR 8:49a | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 11 23 18 64 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | |
| 10. CITY OR TOWN OF DEATH Bowie | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bowie Health Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK) Administrative Off. Diagnostic Radiology | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE MD | | | 13b. COUNTY PG | | | 13c. CITY OR TOWN Bowie | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 12210 Madely Lane 20715 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Russell Edward Rankin | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara E. Bishop | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | | | 16b. SOCIAL SECURITY NO. WW 11, Korea 200-18-2769 | | 17. INFORMANT Mildred U. Rankin ADDRESS 12210 Madeley Lane Bowie, Maryland 20715 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Said A. Daee | | | | | | TITLE (SPECIFY) Deputy M.D. | | MEDICAL EXAMINER | | DATE 9/14/83 SIGNED | | |
| EXAMINER'S NAME (TYPE OR PRINT) Said A. Daee, M.D. | | | | | | ADDRESS 5632 Annapolis Rd. #10 Bladensburg Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept. 16, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery Arlington | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Virginia | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home, Bowie, Md. 20715 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) IRMA H RASCHER | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT 25-1983 | | | 2b. HOUR 6 A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MAY 20 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH P. C. MD. | |
| 10. CITY OR TOWN OF DEATH CLINTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | |
| 13a. STATE Maryland | | 13b. COUNTY Pr Geo | | 13c. CITY OR TOWN Forest Hgts | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walbemar | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena Lange | | 12b. KIND OF BUSINESS OR INDUSTRY Dept Store | | 13e. STREET ADDRESS 23 North Huron Drive | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 579 09 6105 | | 17. INFORMANT ADDRESS Willcrest Hgts, Md Willard C McBride 4113 Blacksnake Dr | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a) **CARDIORESPIRATORY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

(b) **CEREBRAL VASCULAR ACCIDENT**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-23 , 19 83 , to 9-25 , 19 83 , that (I) (we) lost saw the deceased alive on 9-24 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Danilo G. Lee | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-25-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANILLO G. LEE | | | | 22e. ADDRESS 7700 OLD BRANCH AVENUE CLINTON MD 20735 | | | |

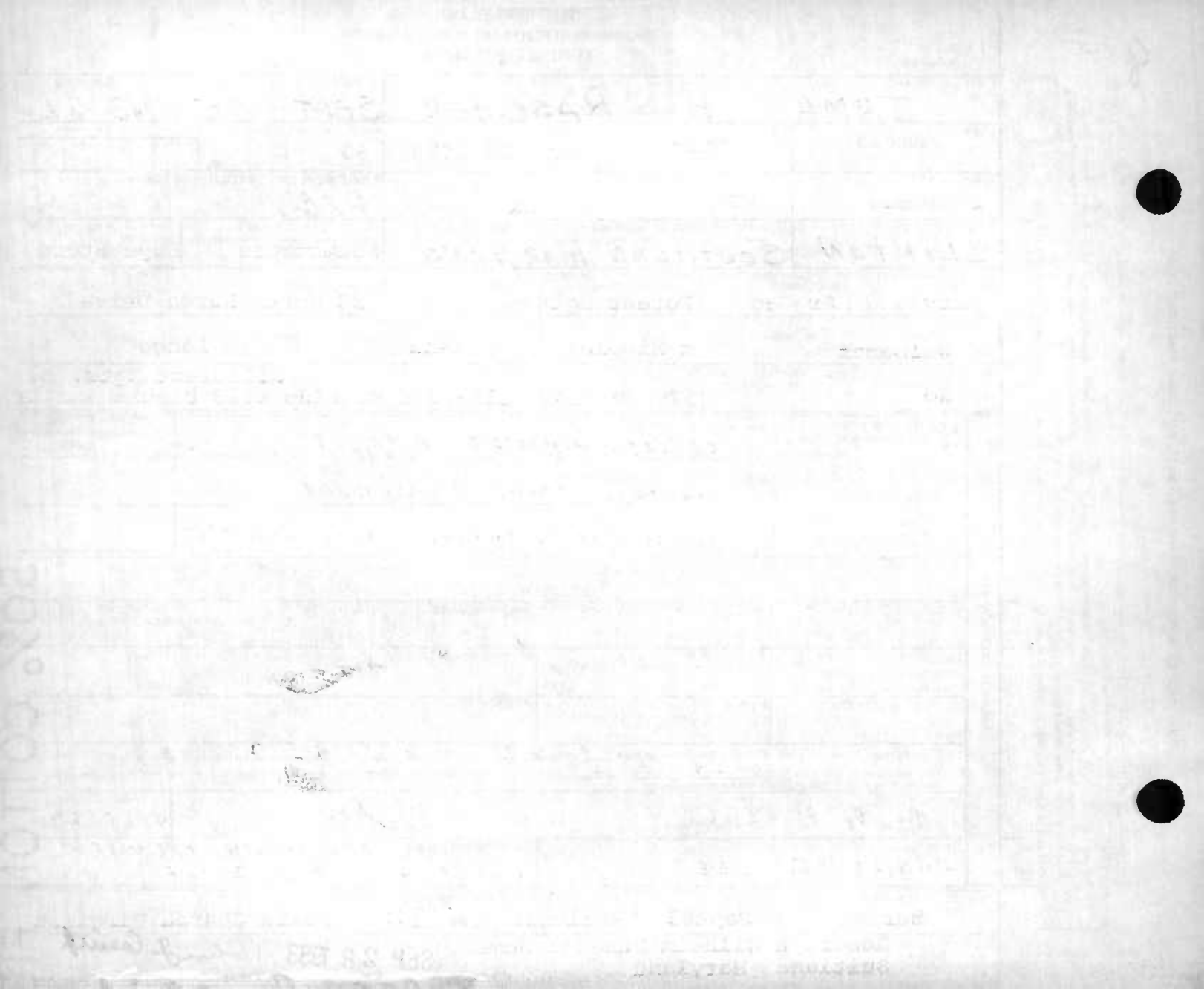
| | | | | | | | |
|--|--|---------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 26Sept83 | | 23c. NAME OF CEMETERY OR CREMATORY National Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Virginia | |
| 24. FUNERAL DIRECTOR'S NAME Robert E Wilhelm | | | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1983 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |
| 24. FUNERAL HOME Suitland Maryland | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25216 | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Thomas Reddington | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 10 83 | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 8 14 85 | | 6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland | | 7b. CITIZEN OF WHAT COUNTRY? Ireland | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Pring Georges MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Convalescent Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bartender | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE District of Columbia | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown | | | | 16b. SOCIAL SECURITY NO. 598-01-7369A | | 17. INFORMANT ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Arteriosclerotic Heart Disease (b) Coronary Artery Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/15 , 19 83 , to 9/10 , 19 83 , that (I) (we) lost saw the deceased alive on 9/9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R. M. ... | | | | DEGREE | | 22c. DATE SIGNED 9/10/83 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) REED MONTAGUE | | | | 23b. ADDRESS 4233 26 Ave md 20746 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 9/10/83 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE John J. ... | |

10003

Barbender

9/10/83

Removal

Amatory Board

Ref. 10003

10003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MELISSA ANN REESE | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 6, 1983 | | 2b. HOUR 5:37p M |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 6, 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 02 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH ANDREWS AFB | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY CHARLES | | 13c. CITY OR TOWN INDIAN HEAD |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES ROBERT REESE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARBARA SUE SYMANSKY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS JAMES R. REESE 38 PERKONS ST, INDIAN HEAD MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 7611 DUE TO, OR AS A CONSEQUENCE OF (b) Premature Rupture of Membranes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 6 , 19 83 , to SEPT 6 , 19 83 , that (I) (we) lost see the deceased alive on SEPT 6, 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE E. Thompson | | | | 22c. DATE SIGNED 7 Sept 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD M. THOMPSON, CAPT, MC | | | | 22e. ADDRESS MALCOLM GROW USAF MED CEN AAFB, MD 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 8, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | |
| 23d. LOCATION CITY OR TOWN Suitland | | COUNTY P.G. | | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Maryland | | ADDRESS SEP 13 1983 | | 25a. DATE REC'D. BY REGISTRAR John J. Carver | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25218 | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MICHAEL CHRISTOPHER REESE | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 6, 1983 | | 2b. HOUR 5:42p M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 6, 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS .02 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH ANDREWS AFB | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY CHARLES | | 13c. CITY OR TOWN INDIAN HEAD | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES ROBERT REESE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARBARA SUE SYMANSKY | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS JAMES R. REESE 38 PERKONS ST., INDIAN HEAD, MD | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 18b. SOCIAL SECURITY NO. | | 18c. CITY OR TOWN | | 18d. STATE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7611 Prematurity DUE TO, OR AS A CONSEQUENCE OF (b) Premature Rupture of Membranes DUE TO, OR AS A CONSEQUENCE OF (c) Premature Rupture of Membranes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT 6 , 19 83 , to SEPT 6 , 19 83 , that (I) (we) last saw the deceased alive on SEPT 6 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) visit the body after death. | | | | | | | |
| 23a. SIGNATURE Edward Thompson | | | | DEGREE | | 23c. DATE SIGNED 07 SEPT 83 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD M. THOMPSON, CAPT, MC | | | | 23d. ADDRESS MALCOLM GROW USAF MED CEN, AAFB, MD 20331 | | 23e. DATE REC'D. BY REGISTRAR SEP 13 1983 | |
| 23f. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23g. DATE Sept. 8, 1983 | | 23h. NAME OF CEMETERY OR CREMATORY Gedar Hill Crematory | | 23i. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland | |
| 24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Maryland | | | | 24b. ADDRESS | | 24c. REGISTRAR'S SIGNATURE J. C. C. C. | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS ANTICIPATED. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25219 | |
|--|----------------------|--|--|--|---|---|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN RELIFORD | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 9-19-83 | | 2b. HOUR 6:54A | | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Feb 3, 1953 | 6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 9-19-83 | | 2d. HOUR 6:54A | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Brandywine | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 301 nr. Clymer Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE MD. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Oxon Hill | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2110 Alice Ave #101 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Reliford Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Herbert | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 577-72-7813 | | | 17. INFORMANT ADDRESS Mable Morgan (Sister) Same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8149 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject struck by auto(s) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy. | | | 21f. LOCATION (CITY OR TOWN, STREET, COUNTY, STATE) Rt. 301 nr. Clymer Ave. Brandywine, Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margie A. Koroll | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 9-19-83 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 23 Sept 83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Breewood MD. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS FRAZIER'S FUNERAL HOME 389 R.I Ave. N.W. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1983 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

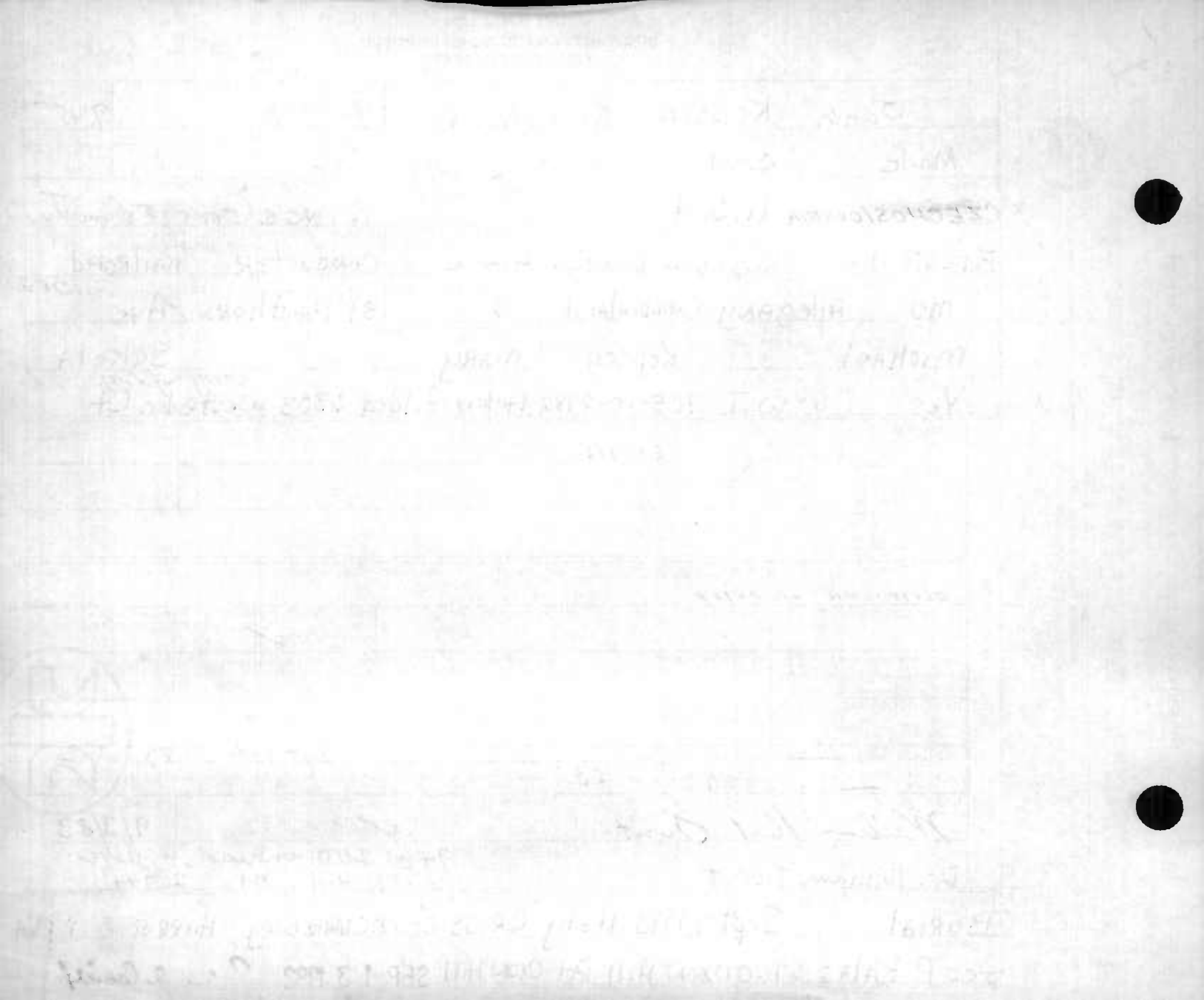
FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25220

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) John Kopson Richmond | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-3-83 | | | 2b. HOUR MIN. 7:45 AM | | | |
| 3. SEX Male | | 4. RACE Caucas | | 5. DATE OF BIRTH MONTH DAY YEAR 02 24 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 86 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) CZECHOSLOVAKIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD. | | | |
| 10. CITY OR TOWN OF DEATH Forestville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Conductor | | 12b. KIND OF BUSINESS OR INDUSTRY RAILROAD | |
| 13a. STATE md | | 13b. COUNTY Alegany | | 13c. CITY OR TOWN Cumberland | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 31 Hawthorn Ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael Kopson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Sekela | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | | |
| 16b. SOCIAL SECURITY NO. 705-10-2982 | | 17. INFORMANT Helen Gilden ADDRESS: Camp Springs, Md. 6303 Westridge Ct | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): obstructive emphysema | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to Sept 3rd , 19 83 , that (I) (we) last saw the deceased alive on Aug 27th , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE William Kurt Junst | | | DEGREE | | | 22c. DATE SIGNED 9/3/83 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William Furst | | | 22e. ADDRESS 9401 Indianhead Highway Oxon Hill Md 20544 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE Sept 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE CHARLSBURG HARRISON W. VA | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Geo P Kalas 6160 Oxon Hill Rd Oxon Hill | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | REGISTRAR'S SIGNATURE P. J. Conish | | | | |

BP _____



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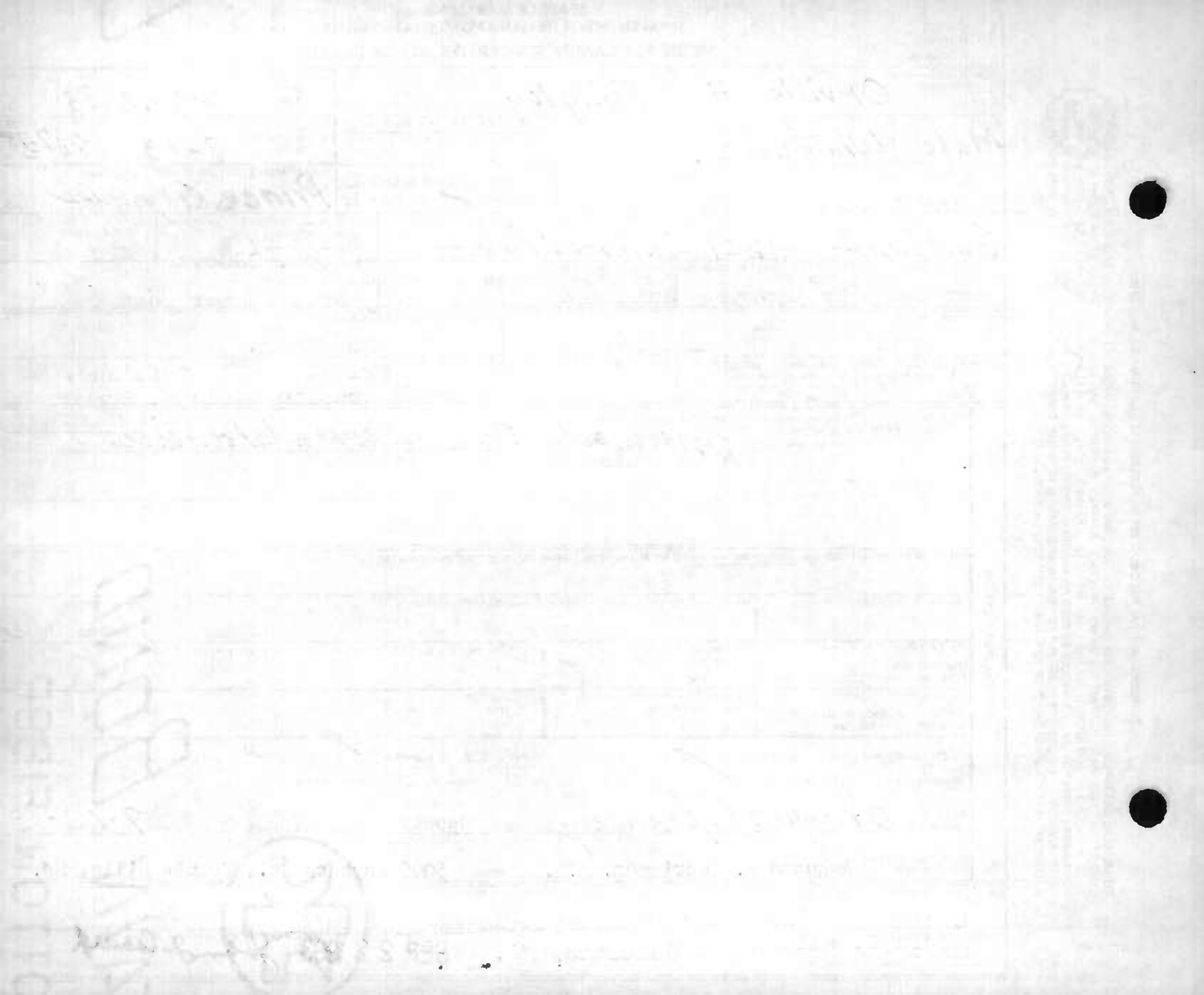
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25221 | |
|---|-------------------------|--|--|--|-----------------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Orville H. Ridgley</i> | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <i>9-13-83</i> | | 2b. HOUR M <i>83</i> | | 2c. DATE PRONOUNCED DEAD <i>9-13-83</i> | |
| 3. SEX <i>Male</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>Jan 17, 1895</i> | 6. AGE IN YEARS (LAST BIRTHDAY) <i>88</i> YRS. | 7. UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | 10. CITY OR TOWN OF DEATH <i>Suitland</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3601 Summer Road</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | 10. CITY OR TOWN OF DEATH <i>Suitland</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3601 Summer Road</i> | |
| 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Military & Elect. USGovt</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>GPO</i> | | 13a. STREET ADDRESS <i>3601 Summer Road</i> | | 13b. CITY OR TOWN <i>Suitland</i> | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS <i>3601 Summer Road</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Unk Ridgley</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Not Known</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i> | | 16b. SOCIAL SECURITY NO. <i>WWI WWII</i> | | 17. INFORMANT <i>Friend</i> | | 17. ADDRESS <i>Suitland, Md</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Interpelvetic candidous vulv disease</i> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) <i>Deputy</i> MEDICAL EXAMINER | | DATE SIGNED <i>9-13-83</i> | | ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> M.D. | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i> | | ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md.</i> | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>17 Sept 83</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Washington National</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland PG Md</i> | |
| 24. FUNERAL DIRECTOR <i>Robert E. Wilhelm</i> | | ADDRESS <i>Suitland, Md.</i> | | 25. DATE RECD. BY REGISTRAR'S REGISTRATION SIGNATURE <i>SEP 22 1983</i> | | 25. DATE RECD. BY REGISTRAR'S REGISTRATION SIGNATURE <i>John J. Gault</i> | | 25. DATE RECD. BY REGISTRAR'S REGISTRATION SIGNATURE <i>John J. Gault</i> | | 25. DATE RECD. BY REGISTRAR'S REGISTRATION SIGNATURE <i>John J. Gault</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25222 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 20. DATE OF DEATH MONTH DAY YEAR 09 11 83 4:00PM M | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST LUTHER B ROBERTSON | | | | 2b. HOUR | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 6-11-21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Southern Maryland Hospital Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE MD. | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN MORNINGSIDE | | 13e. STREET ADDRESS 6708 Suitland Rd. 20746 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN JOSEPH ROBERTSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE HATHEB KLINE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. W.W.11 578-16-8944 | | 17. INFORMANT MICHAEL ROBERTSON | | ADDRESS SAME #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac pulmonary arrest 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma of left lung DUE TO, OR AS A CONSEQUENCE OF (c) massive gastro-intestinal bleeding APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours months days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Cardiac myopathy, chronic obstructive pulmonary disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-8, 1983, to 9-11, 1983, that (I) (we) last saw the deceased alive on 9-11, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Peter W. Yim M.D. | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-11-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER W. YIM M.D. | | 22e. ADDRESS 7900 Old Branch Ave. Suite 101 Clinton, Maryland 20735 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 9-14-83 | | 23c. NAME OF CEMETERY OR CREMATORY CEDARHILL CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. Md. | |
| 24. FUNERAL DIRECTOR NAME ROBERT E. WILHELM | | ADDRESS FUNERAL - SUITLAND | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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Handwritten signature or text at the bottom left corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|------------|---|-------------------|--|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST HUGH | | MIDDLE RUSSELL | LAST ROBEY | | 2a. DATE OF DEATH | | 2b. HOUR |
| 3. SEX M Male | | 4. RACE W Caucasian | | 5. DATE OF BIRTH 9/19/43 | | 6. AGE 39 | | 7. DATE OF DEATH 9/17/83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George | | 10. USUAL OCCUPATION Engineer | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Community Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Govt. | | 12c. STATE Mont. Co. | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Severn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7887 Huguenot Court 21144 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Russell Woodrow Robey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Camilla Tingstrom | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-42-2859 | | 17. INFORMANT SPOUSE Marilyn S. Robey | |
| 18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Postoperative Edema, CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metabolic CA due to the drugs</u> | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COMPLICATION GIVEN IN PART 1: <u>Diarrhea, Primary colon cancer</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-15, 1983, to 9-17, 1983, that (I) (we) last saw the deceased alive on 9-17-83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>Glenn R. Jancison</u> | | 22c. DATE SIGNED 9/17/83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Glenn R. Jancison | | 22e. ADDRESS 3990 Penn. Ave. Upper Marlboro MD 20772 | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-20-83 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gdns. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland | | 24b. ADDRESS Huntt Funeral Home, Waldorf, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 20 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u> | | | |

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) RUTH C. ROGERS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 9 83 2b. HOUR 5:30 AM | | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH May 16 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Cty. MD. | | | |
| 10. CITY OR TOWN OF DEATH Greenbelt | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Home | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY Private Sch | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN Greenbelt | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7830 Hanover Pkwy. 20770 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Thurston Collins | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine ---- Rathburn | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Ida Saymon Same as #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ovarian Carcinoma 1830 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-2 19 83 , to 9-9 19 83 , that (I) (we) last saw the deceased alive on 9-1 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE David Schachter | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 9-10-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID Schachter | | | | | 22e. ADDRESS 115 Gentryway Greenbelt Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 9 83 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | |

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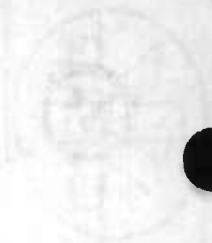
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | | |
|--|--|---|---|---|---|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM JOHN ROWE JR. | | | | | SEPTEMBER 21, 1983 | | | | | 8:08p M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 22 1943 | | 6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH ANDREWS AFB | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) JET ENGINE MECH | | 12b. KIND OF BUSINESS OR INDUSTRY MILITARY | | | |
| 13a. STATE NEW JERSEY | | 13b. COUNTY OCEAN | | 13c. CITY OR TOWN TOM RIVER | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1232 AUDUBON DRIVE 99999 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM JOHN ROWE | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret I. Rowe | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES 1963-1983 | | | | | 16b. SOCIAL SECURITY NO. 135-34-0983 | | 17. INFORMANT ADDRESS PATRICIA A. ROWE 1232 AUDUBON DR, TOM RIVER, NEW JERSEY | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest CARDIAC ARREST 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) severe cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF SEVERE CARDIOVASCULAR DISEASE (c) SEVERE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, YARD, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 21 Sep 19 83 to 21 Sep 19 83 , that (I) (we) last saw the deceased alive on 21 Sep 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Kurt Harding | | | | | DEGREE DO ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 21 Sep 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KURT HARDING, MD | | | | | 22e. ADDRESS MALCOLM GROW USAF MED CEN AAFB, MD 20331 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9-24-83 | | 23c. NAME OF CEMETERY OR CREMATORY Ocean County Mem. Pk Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Toms River, N.J. | | | |
| 24. FUNERAL DIRECTOR Marshall's Funeral Home 4217 9th St. NW: Washington, D.C. | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25220 | | |
|--|------------------|---|--|---|--|---|--|---|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 7a. DATE KNOWN OF DEATH | | 7b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy Rome Ruchl | | | | | | | | | | MONTH 9 DAY 25 YEAR 83 | | 10:30 AM |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH (MONTH DAY YEAR) 5-12-35 | | 6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 9-25-83 | | 7d. HOUR 10:30 AM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH New Carrollton | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5904 Westbrook Fee | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) - N/A - | | 12b. KIND OF BUSINESS OR INDUSTRY - N/A - | | | |
| 13a. STATE MD | | | | | | | | | | 13b. CITY OR TOWN New Carrollton | | 13c. STREET ADDRESS 20784 terrace |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Joseph (NA) Rome | | | | | | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Helen (NA) Kozel | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) - NO - | | 16b. SOCIAL SECURITY NO. 268-30-6469 | | 17. INFORMANT ADDRESS Charles Ruchl (Same as #13) | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE SAND A. DASE MD | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 9-25-83 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis | | | | ADDRESS Bladensburg MD 20710 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 27 Sept 83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN Seaford COUNTY PG. STATE MD | | | | | | |
| 24. FUNERAL DIRECTOR NAME Helen Longm Etl ADDRESS 9015 Annapolis Rd | | | | 25a. DATE REC'D. BY REGISTRAR 20786 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | | | | |



U.S. GOVERNMENT PRINTING OFFICE: 1964 O 354-100

U.S. GOVERNMENT PRINTING OFFICE: 1964 O 354-100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

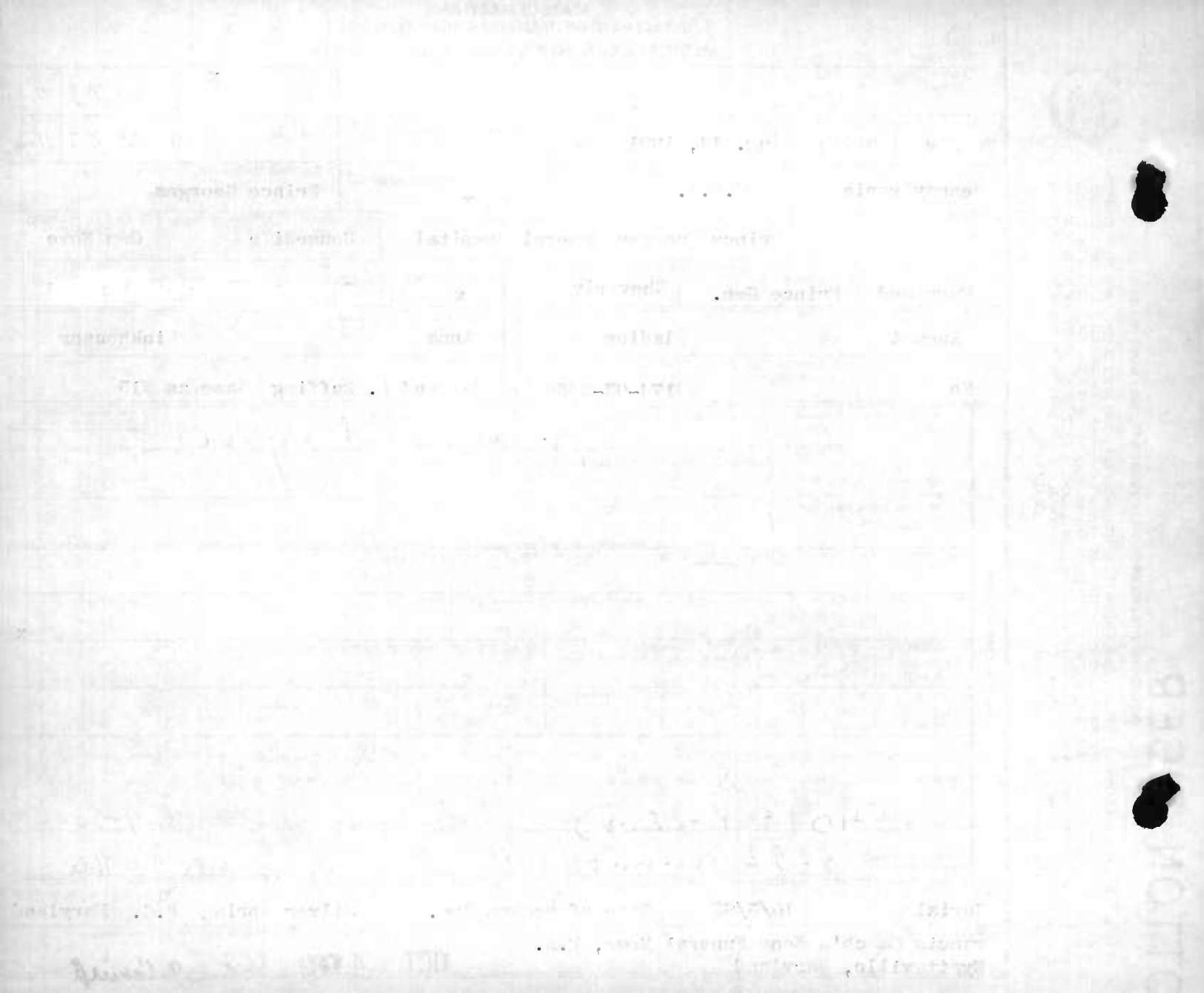
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25227

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------|------------------|---|-----------------|---|--------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST NORA LORETTA RUFFING | | | MONTH DAY YEAR 9 29 1983 | | | 11.25 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | |
| Female | White | Aug. 14, 1901 | 82 | MONTHS | DAYS | 9 29 1983 | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pennsylvania | | | U.S.A. | | | Prince Georges | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince Georges General Hospital | | | Own Home | | |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12c. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. STREET ADDRESS | | |
| Maryland | | | Prince Geo. | | | 5605 Jason Street 20785 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | |
| August | | | Anna | | | 174-03-2269 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| No | | | 174-03-2269 | | | Raymond L. Ruffing Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | |
| 4148 | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
| SAID A. DARRIN | | | Deputy | | | 9-30-83 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | |
| 5632 Annapolis Rd | | | Bladensburg MD 20710 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | | 10/3/83 | | Gate of Heaven Cem. | | Silver Spring P.G. Maryland | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Francis Gasch's Sons Funeral Home, P.A. | | | | | OCT 4 1983 | | John J. Connelley | |
| Hyattsville, Maryland | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25228 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST KATHLEEN MARION RUSSELL | | | | SEPTEMBER 30, 1983 | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR June 30, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Canada | | 7b. CITIZEN OF WHAT COUNTRY? Canada | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH LANHAM | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO. | | 12. USUAL OCCUPATION Medical Secretary | | 13. BUSINESS OR INDUSTRY Surgeon | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN Greenbelt | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Limage | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orpha Snively | | 13e. STREET ADDRESS 8405 Greenbelt Road 20770 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220 60 2115 | | 17. INFORMANT ADDRESS William Russell Same as #13 (Husband) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral Encephalitis</u> <u>0499</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/30</u> 19 <u>83</u> to <u>9/30</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>GABRIEL JAFFE</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9/30/83</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GABRIEL JAFFE, MD | | | | 22e. ADDRESS 5711 SARVIS Ave Riverdale MD 20857 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (S) <u>Cremation</u> | | 23b. DATE <u>10/1/83</u> | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION Alexandria COUNTY VA. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | 25. DAY RECEIVED BY REGISTRAR <u>9/30/83</u> | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY J RYAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 4 83 | | | 2b. HOUR 5⁰² P^M | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 27 96 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Conv. Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC | |
| 12b. KIND OF BUSINESS OR INDUSTRY US GOVT. | | | | 13a. STREET ADDRESS 20748 # 102 2737 BRINKLEY RD. | | | |
| 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13c. CITY OR TOWN Temple Hills | | | |
| 13d. STATE MD. | | | | 13e. COUNTY PG | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES E. RYAN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH A. BRADLEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 204-10-1255 | | 17. INFORMANT 544 CHESTNUT ST MEADVILLE PA. | |
| 16c. (IF YES, GIVE WAR OR DATES) | | | | 17. ROOFNER FUNERAL HOME | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **MULTIPLE STROKES**
3400
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) **ARTERIOSCLEROSIS**
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

WEEKS

YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

ORGANIC BRAIN SYNDROME

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (the hospital) attended the deceased from **10-15**, 19**82**, to **9-4**, 19**83**, that (I) (we) lost saw the deceased alive on **19**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

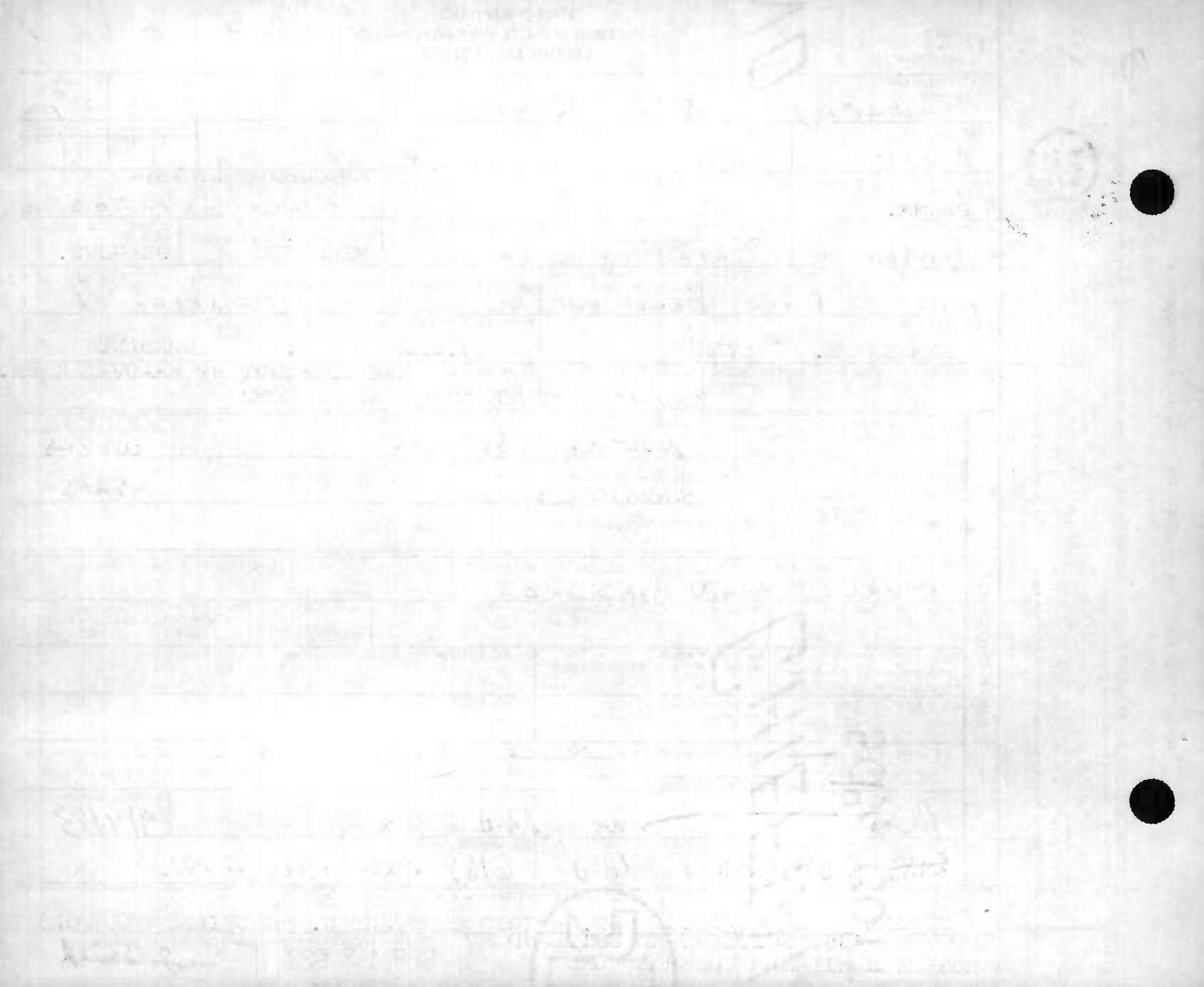
| | | | | | |
|--|--|---|--|-----------------------------------|--|
| 22b. SIGNATURE PWS | | DEGREE M.D. | | 22c. DATE SIGNED 9/4/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) 6188 P. WLOSZYK M.D. | | 22e. ADDRESS 6188 OXON HILL ROAD. | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 9/8/83 | | 23c. NAME OF CEMETERY OR CREMATORY ST. BRIGID CEMETERY W. MEADVILLE CRAWFORD PA | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR ROBERT E WILHELM FUNERAL HOME | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR <i>William F. Ryder</i> | | REG. NO. 25230 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William F. Ryder</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>09 15 83</i> | | 2b. HOUR <i>10:55 P.m.</i> | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>March 26, 1916</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>CLINTON</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Md Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Mechanic</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Typewriter</i> | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>PR George</i> | | 13c. CITY OR TOWN <i>Lothian</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>298 Waysons Mobile Court</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John Ryder</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Clara Colvin</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>224-12-5481</i> | | 17. INFORMANT ADDRESS <i>Mildred V. Ryder Same as #13</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>4479</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sp. Aorta femoral Bypass</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 Hour</i> <i>8 HRS</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION <i>9/15/83</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Aorta Aortic Disease</i> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-14</i> to <i>9-15</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>9-15-83</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>B. S. Grover</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <i>9-16-83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. S. GROVER</i> | | | | 22e. ADDRESS <i>7501 Swatts Rd. CLINTON, MD.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>19 Sep 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Washington National</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland PG Md</i> | | | |
| 24. FUNERAL DIRECTOR <i>Robert E. Wilhelm</i> <i>Funeral Home</i> | | | | ADDRESS <i>Suitland, Md</i> | | 25a. DATE REC'D. BY REGISTRAR <i>SEP 22 1983</i> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>John J. Gainer</i> | | | | | |

BP

RECEIVED
JAN 10 1954
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]



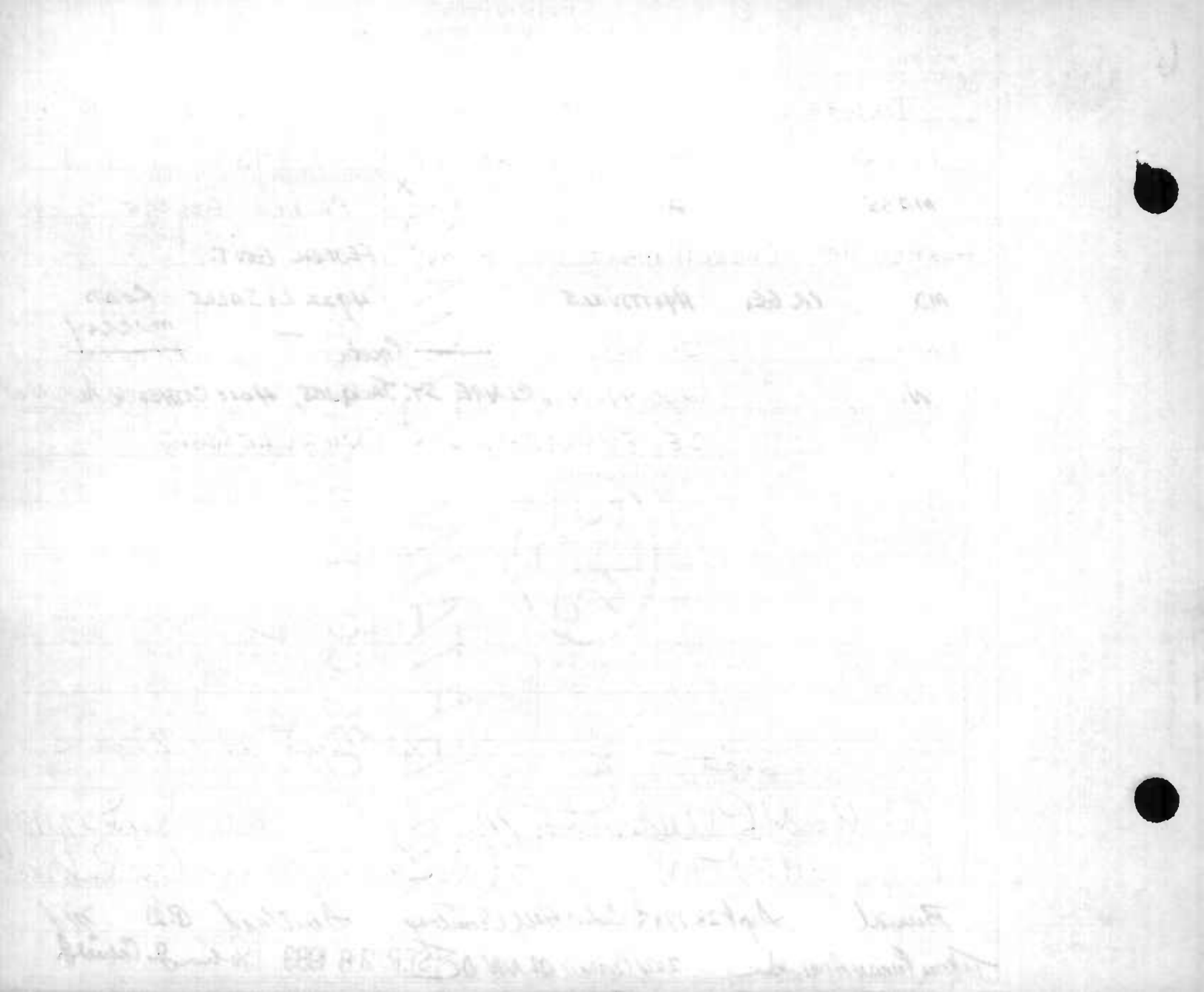
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25231 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST Delores St. Jacques | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9-26-83 | | | |
| 3. SEX Female | | | | 2b. HOUR 10⁵⁰ PM | | | |
| 4. RACE White | | | | 5. DATE OF BIRTH MONTH DAY YEAR 2-28-87 | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE. MD. | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL Manor Nsg Home | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FEDERAL GOVT. | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD. | | | | 13b. COUNTY PR GE | | | |
| 13c. CITY OR TOWN HYATTSVILLE | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS 4922 LA SALLE ROAD | | | | 20. STREET ADDRESS 4922 LA SALLE ROAD | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST PAUL St. Jacques | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MURRAY Phoebe | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N. | | | | 16b. SOCIAL SECURITY NO. 220-44-0626 | | | |
| 17. INFORMANT ADDRESS CLARE ST. JACQUES, 4000 CATHEDRAL AVE. NW | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) GENERALIZED ARTERIOSCLEROSIS | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | 21d. INJURY OCCURRED | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 7 1983 to Sept 26 1983 , that (I) (we) last saw the deceased alive on Sept 7 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard L. Whifflon | | | | 22c. DATE SIGNED Sept 27, 1983 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. WHIFFLON | | | | 22e. ADDRESS 7100 Baltimore Ave College Park Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sept 28-1983 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE District C.D. Md | | | |
| 24. FUNERAL DIRECTOR NAME Takom Funeral Home Inc. | | | | 25. DATE REC'D. BY REGISTRAR SEP 28 1983 | | | |
| 25. REGISTRAR'S SIGNATURE John J. Carver | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DECEASED WAS A FUGITIVE, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25232 | |
|---|--|------------------|--|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Mary Henrietta Sample | | | | | | | | | | 2a. DATE KNOWN OF DEATH 9 27 1983 | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH June 8, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | 7b. HOUR 6.30 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD 9 27 1983 | |
| 10. CITY OR TOWN OF DEATH Seat Pleasant | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6416 Seat Pleasant Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Seat Pleasant | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6416 Seat Pleasant PL. | |
| 14. FATHER'S NAME Henry Williams | | | | | | 15. MOTHER'S MAIDEN NAME Mary Sweetnie | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | | | 16b. SOCIAL SECURITY NO. 577 32 3765A | | 17. INFORMANT Mrs. Marion Williams-daughter-6416 Seat Pleasant Drive, Seat Pleasant | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hutnig Chorea 3334 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Sgt. A. DASH MD | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 9-27-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) 3632 annapolis Rd | | | | ADDRESS Bladensburg MD 20710 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park Landover Maryland | | | | 23c. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR Stewart Funeral Home | | | | 24a. ADDRESS 4001 Benning Road | | | | 24b. DATE REC'D. BY REGISTRAR 4 1983 | | | |
| | | | | 24c. REGISTRAR'S SIGNATURE John J. Lohr | | | | | | | |

1944

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|--|--------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Teresa (nmn) SANDERS | | | 2a. DATE OF DEATH MONTH DAY YEAR September 19, 1983 | | 2b. HOUR 6:20p | | |
| 3. SEX Female | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR June 24 1951 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 32 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't. | |
| 13a. STATE MD | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Riverdale | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jimmie Sanders | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gracien Buchanan | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. UNKNOWN | |
| 17. INFORMANT Gracien Sanders | | ADDRESS 5409 Riverdale Rd. #24 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE 4331 DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN DEATH DUE TO, OR AS A CONSEQUENCE OF (c) LEFT INTERNAL CAROTID ARTERY THROMBOSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day More than 3 days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) RIGHT ATRIAL ENDOCARDIAL ATRIUM VALVE VEGETATION | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/19/83 to 9/20/83 , that (I) (we) lost saw the deceased alive on 9/19/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Syed A. Sadiq | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Syed A. Sadiq M.D. | | 22e. ADDRESS 14201 Laurel Pk. Dr., Laurel, Md. 20707 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 4-27-83 | | 23b. DATE | |
| 23c. NAME OF CEMETERY OR CREMATORY HARMONY CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lanham, MD | | 24. FUNERAL DIRECTOR NAME H.S. Washington | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | |
| 25b. REGISTRAR'S SIGNATURE John J. Connel | | 25c. REGISTRAR'S SIGNATURE | | 25d. REGISTRAR'S SIGNATURE | | 25e. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE INMAN
BOX COTTON



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Alexander SANISLO | | | 2a. DATE OF DEATH MONTH DAY YEAR September 16, 1983 | | | 2b. HOUR 5:35p.m. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 16 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of P.G. County | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Leather Cotter | |
| 13a. STATE Florida | | 13b. COUNTY Lee | | 13c. CITY OR TOWN Cape Coral | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Szanislo | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Kara | | 12b. KIND OF BUSINESS OR INDUSTRY Shoes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 141-05-3525 | | 17. INFORMANT Elizabeth S. Sanislo Same as 13e | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1519

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Bronchopneumonia

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION 9/9/83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Jejunostomy | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 9 1983 to Sept 16 1983 that (I) (we) last saw the deceased alive on Sept 15 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If completed, did not view the body after death.) | | | | | | | |
| 22b. SIGNATURE W.P. Jones-Key | | DEGREE | | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/16/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WENDY P. JONES-KEY | | 22e. ADDRESS 9470 Annapolis Rd Lanham | | | | | |

| | | | | | | | |
|---|--|-------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-20-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hopelawn Middlesex N. J. | |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons, P. A. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1983 | | | |
| ADDRESS Hyattsville, Maryland | | | | REGISTRAR'S SIGNATURE John J. Connel | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST Andrew Leroy Savoy | | | | MONTH DAY YEAR 9 19 83 | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 - 1 - 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Farm + Constr. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | 13b. COUNTY P.G | | 13c. CITY OR TOWN Aguasco | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew Savoy | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Proctor | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-18-1569 | |
| 17. INFORMANT ADDRESS Agnes L. Savoy SAA | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 10 mo | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Dec 13, 19 82</u> to <u>Sept 19, 19 83</u> , that (I) (we) last saw the deceased alive on <u>Sept 17, 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Thomas L. Fieldon M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/19/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Fieldon, M.D. | | | | 22e. ADDRESS Brandywine, Md/ 20613 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-23-83 | | 23c. NAME OF CEMETERY OR CREMATORY St. Peters Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Md | |
| 24. FUNERAL DIRECTOR NAME Mantell Adams | | | | ADDRESS Aguasco MD 20608 | | 25a. DATE REC'D. BY REGISTRAR SEP 26 1983 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | |

BP

52 31 P

total

total

total

20% GOLFOM

WILEY



Item 4 per phone 11/17/83 dad
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mildred E. Y. Schellinger | | | 2a. DATE OF DEATH MONTH DAY YEAR 9/9/83 | | | 2b. HOUR 3:20 AM | | | | | |
| 3. SEX F | | 4. RACE C White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 16 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Greenbelt | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt nsg. center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Traffic Director | | 12b. KIND OF BUSINESS OR INDUSTRY Radio | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY PG | | 13c. CITY OR TOWN Seabrook | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6503 96th Ave | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Charles Young | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Troy Brals | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579104206A | | 17. INFORMANT ADDRESS Charles Schellinger 6503 96th Ave - Seabrook | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) Terminal Bladder Cancer DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Brain Syndrome | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 M. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 79 to 9 9 1983, that (I) (we) lost saw the deceased alive on 9 8 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-9-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHANNES SAHAKIAN | | | | | | 22e. ADDRESS 5632 Annandale Rd | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 9 Sept 83 | | 23c. NAME OF CEMETERY OR CREMATORY Lees Funeral home | | 23d. LOCATION (CITY OR TOWN) Glenview | | 23e. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 24. FUNERAL DIRECTOR NAME Helen Lanham | | | | | | 24b. ADDRESS 414 9013 Annapolis Rd | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1983 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

[Faint, mostly illegible handwriting on lined paper. The text appears to be a letter or a series of notes, with some words like "Dear" and "I" visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25237

FOR
1. STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY LYDIA SHAVIER | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPT 13 1983 | | | 2b. HOUR 11:00 PM | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR APR 9 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | |
| 10. CITY OR TOWN OF DEATH CLINTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8607 OLD BRANCH AVE. CLINTON, MD. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME |
| 13a. STATE MD. | | | 13b. COUNTY PR. GEO. | 13c. CITY OR TOWN CLINTON | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM ALFRED SIMPSON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA SIMPSONIA MORAN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT ADDRESS 8605 Old Branch Avenue Arthur Shaver, Sr. - Clinton, Maryland | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN 1 HOUR |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CARCINOMA OF STOMACH

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION AUG 31 '83 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENOCARCINOMA OF STOMACH | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART FOR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from **9/12**, 19 **83**, to **9/13**, 19 **83**, that (I) (we) last saw the deceased alive on **9/12**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|--|---------------------|---|
| 22b. SIGNATURE G. H. NACHNANI | DEGREE MD | 22c. DATE SIGNED 9/13/83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. H. NACHNANI | | 22e. ADDRESS 9015 WOODYARD ROAD, CLINTON MD |

| | | | |
|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE September 16, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Pr. Geo., MD |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR SEP 16 1983 | |
| 25b. ADDRESS Old Alexander Ferry Road, Clinton, Maryland | | 25c. REGISTRAR'S SIGNATURE John J. Canine | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Margaret R. Shea | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 03 '83 | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 11 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 13a. STATE Mass. 13b. COUNTY Plymouth 13c. CITY OR TOWN Scituate | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 22 Mary's Lane 99999 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Patrick Barry | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Barry | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 031-40-7766 | | 17. INFORMANT ADDRESS Robert Shea 8 Whittier Pl. Boston, Mass. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4049 DUE TO, OR AS A CONSEQUENCE OF (b) ARTS/CAR. REN. VAS D IS HEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC BRAIN SYNDROME | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-6 80 to 9-3 85, that (I) was lost saw the deceased alive on 9-1 83, and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Frederick W. Schneider MD DEGREE MD | | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK W. SCHNEIDER | |
| 22e. ADDRESS 201-8 ST NE DC 20002 | | | | 22f. MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | 22g. STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 9/7/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Groveland Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE N. Scituate Plymouth Mass. | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave Wash., D.C. 20016 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | |

Joseph Gawler's Sign Inc.

Wash., D.C. 20016
212 Ave. Ave

Printed

9/7/1983

Grove and Cemetery

N. Baltimore Plymouth Mass.

[Faint, illegible text, possibly bleed-through from the reverse side]

X

No

012-22-1379

Robert Shea

8 Whittier Pl. Boston, Mass.

Patrick

Berry

Allen

Berry

Mass. 02000

Plymouth

Coltuate

X

22 Mary's Lane

Hyattsville

Carroll Manor Nursing Home

Homewood

At Home

Mass.

U.S.A.

X

Prince Georges

Feb. 11 1983

90

Harvard

Shea

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Evelyn L. Sherbert | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 7, 1983 | | | 2b. HOUR 11:00A | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 12 21 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | |
| 10. CITY OR TOWN OF DEATH Temple Hills | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4011 Leisure Dr. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY P.G.Co. Police | |
| 13a. STATE Maryland | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Temple Hills | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John A. Bucy | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Rae | | 13e. STREET ADDRESS 4011 Leisure Dr. | | 20748 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-24-4314 | | 17. INFORMANT ADDRESS John R. Sherbert same as item 13 | | | |

| | | | | | |
|--|--|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/24 19 83 , to 9/7 19 83 , that (I) (we) lost saw the deceased alive on 9/7 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Harvey Katzen | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/8/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY KATZEN | | 22e. ADDRESS 7801 Old Branch Ave. Clinton, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/8/83 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME G.P. Kalas | | ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | |
| 25b. REGISTRAR'S SIGNATURE Sam J. Carter | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Ann LAST SHERIDAN | | | | 2a. DATE OF DEATH MONTH 09 DAY 09 YEAR 83 | | | | 2b. HOUR 9:46A M | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH NOV. DAY 9, YEAR 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Bowle | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 15751 Pointer Ridge Road | |
| 14. FATHER'S NAME FIRST Robert Scott MIDDLE McQueen LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Ann LAST Nelson | | | | 20716 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 162-09-4604 | | 17. INFORMANT ADDRESS Robert A. Sheridan Same as 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u> <u>1990</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer probably due carcinomatous</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Tomas J. Hernandez MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9/9/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hernandez | | | | 22e. ADDRESS Prince Georges Hosp. Cheverly, Md 20785 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-14-83 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery | | 23d. LOCATION CITY OR TOWN Philadelpha COUNTY Phla. | | | |
| 24. FUNERAL DIRECTOR NAME Robert E. Evans | | | | ADDRESS 1212 West St. Annapolis, Md. | | | | 25. THIS RES'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE SEP 21 1983 John G. [Signature] | | | |

STANDARD
FORM NO. 1
REV. 1-57

09 03 2152

REPTIAN

WAT

PRINCE GEORGES

PRINCE GEORGES GENERAL HOSPITAL

CHEVELY



20% COTTON

SEP 21 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rowena Mae Shirah | | | | September 9 1983 6:45 PM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 18 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 88 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Beltsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3572 Powder Mill Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY own home | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Beltsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Earlie L. White | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Randle | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A (IF YES, GIVE WAR OR DATES) N/A | | | |
| 16b. SOCIAL SECURITY NO. 578-01-3186 A | | 17. INFORMANT ADDRESS Dorothy Gregory-daughter-(same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTIVE PULMONARY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS 6 MONTHS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u> | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/24/83 to 9/9/83, that (I) (we) last saw the deceased alive on 8/26/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have) (I did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE Dennis J. Hand MD | | DEGREE | | 22b. DATE SIGNED 9/10/83 | | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis J. Hand MD | | 22e. ADDRESS 4600 CONNECTICUT AVE. N.W. WASHINGTON D.C. 20008 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-14-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | 11800 N.H. Ave., Silver Spring, Md. | | 25a. DATE OF DEATH SEP 15 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Hand | |

BP

Misses/Minahd Funeral Home Silver Spring, Md.

11800 W.L. Ave.,

Farmland Cemetery

Belleville, Missouri

7-14-1983

Burial

Redmond

8/21/82

8/21/82

8/21/82

SEP 1982

James J. Hand and Associates

8/21/82

8/21/82

8/21/82

CHURCH OF THE HOLY TRINITY

RESTORATION PROJECT

570-01-2186 A Dorothy Gregory-daughter-(same as 132)

N/A

N/A

L.

White

Male

Female

Maryland

Prince Georges Beltsville

3275 Powder Mill Road, 20705

Beltsville

3275 Powder Mill Road

Beltsville

own home

Georgia

USA

X

Prince Georges

Dec. 18 1894

88

9-10-82

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

2 5 2 4 2

REG. NO.

**1- FOR
STATE
REGISTRAR**

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|--|--|---------------------------------------|--|-----------------------------------|--|--------------------------------------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| MARY ELIZABETH | | | | | | SIMMS | | <input checked="" type="checkbox"/> 9 | | 14 | | 19 | | 83 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Female | Black | NOV 23 1933 | | 49 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 9 | | 14 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | <input checked="" type="checkbox"/> NEVER MARRIED | | <input type="checkbox"/> WIDOWED | | <input type="checkbox"/> DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| VIRGINIA | | U.S.A. | | | | | | | | | | PRINCE GEORGE | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Andrews AFB | | MALCOLM GROW HOSPITAL | | CLERK | | CLEANERS | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD. | | PR. GEORGE | | FORRESTVILLE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 3239 WALTERS LANE # 4 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| JOHN S. THOMAS | | MARY E. JACKSON | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 579 70 9479 | | DANIEL G. SIMMS | | SEE 13 ABOVE | | | | | | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: **Hypertensive cardiovascular disease**

4029

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(a) **DUE TO, OR AS A CONSEQUENCE OF**
(b) **DUE TO, OR AS A CONSEQUENCE OF**
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22b. TITLE (SPECIFY) Deputy | | DATE SIGNED 9/14/1983 | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | M.D. | | MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | |

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 17 SEP 83 | | HARMONY MEM. PARK | | LANDOVER, MD. | |
| 24. FUNERAL DIRECTOR NAME <i>William E. Brown</i> | | ADDRESS 814 FRANKLIN STREET ALEXANDRIA, VIRGINIA 22314 | | 25a. DATE REC'D. BY REGISTRAR 8 SEP 23 1983 | | 25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



VIR. 1111

NATIONAL BROW HOSPITAL

1111 1111 1111 1111

JOHN S. THOMAS

JOHN S. THOMAS

ALL TO GIVE 1111 1111 1111 1111

ALL TO GIVE 1111 1111 1111 1111

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Orig. certifi. illegible.

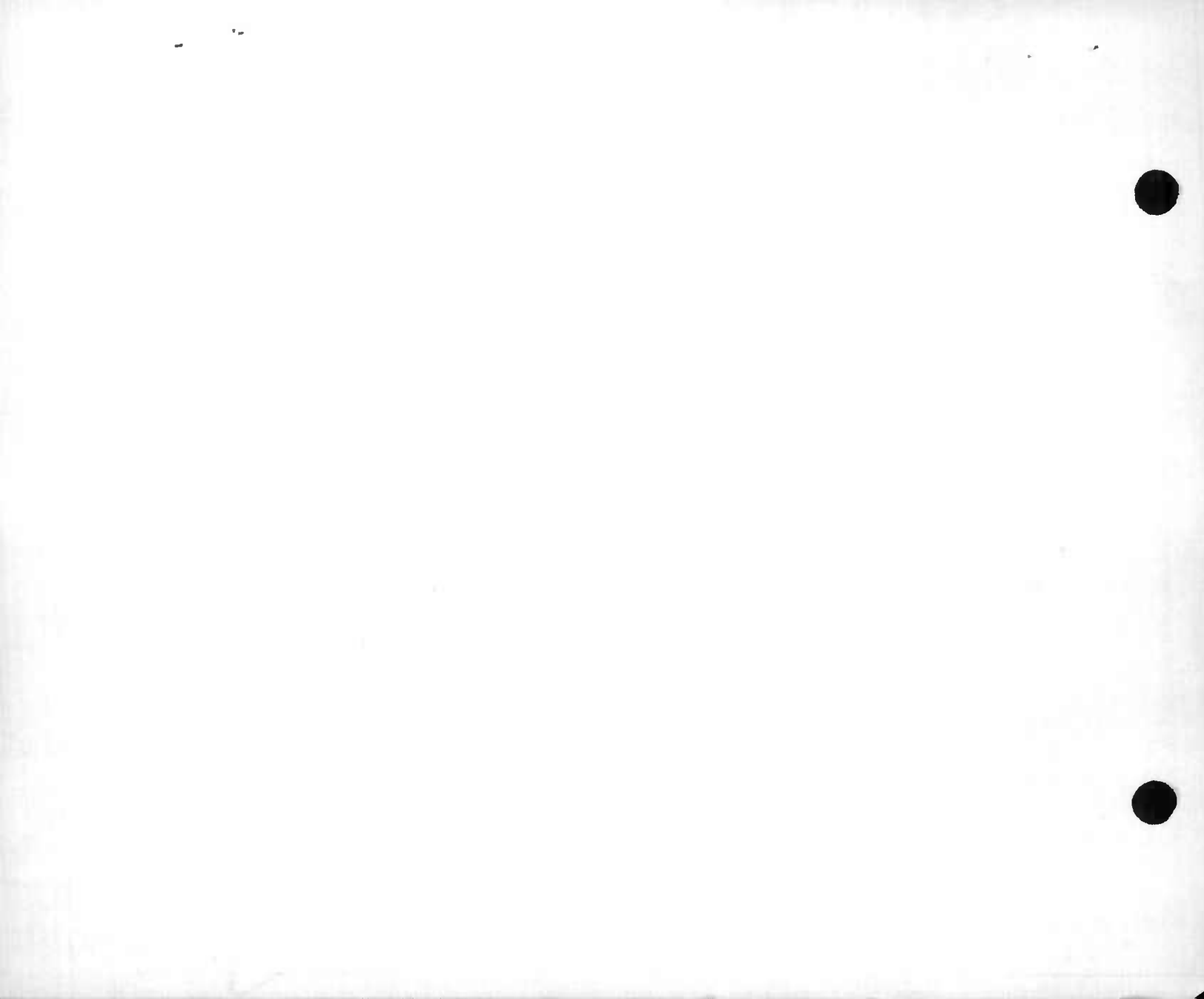
1- STATE REGISTRAR FilmG708 2/28/94 kam
see attached.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 83-25243

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) GEORGE V. SINGLETARY | | | 2a DATE OF DEATH MONTH DAY YEAR 09 09 83 | | | 2b HOUR 4:55 P.M. | | | |
| 3 SEX Male | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR Jan. 27 1940 | | 6 AGE (IN YEARS LAST BIRTHDAY) 43 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD | | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE Maryland | | 13b COUNTY Beltsville | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 542 Springfield Road | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Coleman Singletary | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie M. Kinnear | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 52 9950 | | 17 INFORMANT ADDRESS Jane Singletary-sister-71 V St., N.W. | | | | | |
| II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SARCROIDOSIS WITH PULMONARY FIBROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LEFT PLUERAL EFFUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>RESPIRATORY FAILURE</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>9/9</u> , 19 <u>83</u> , to <u>9-9</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <u>Gerardo M. Galad</u> | | | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c DATE SIGNED <u>9/13/83</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Gerardo M. Galad | | | | 22e ADDRESS 6492 Landover Rd., Landover, Md. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE Sept. 13, 1983 | | 23c NAME OF CEMETERY OR CREMATORY Kelly Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Bladensboro, North Carolina | | | |
| 24 FUNERAL DIRECTOR NAME <u>John I. Stewart III</u> ADDRESS | | | | 25a DATE REC'D. BY REGISTRAR Sep 22 1983 | | 25b REGISTRAR'S SIGNATURE <u>John J. Cahill</u> | | | |
| 26 FUNERAL HOME Stewart Funeral Home, 4001 Benning Rd., N.E. | | | | | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use on the burial/transfer permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reburial.

IMPORTANT: If item 21 is marked per item 18 shows only in Part 1, other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE V. SINGLETARY | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 09 83 | | | 2b. HOUR 4:55 P.M. | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 27, 1940 | | 6. AGE (IN YEARS LAST BIRTHDAY) 43 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | 13b. COUNTY Beltsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS 542 Springfield Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Coleman Singletary | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie M. Kinnear | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR IF UNKNOWN) (IF YES, GIVE WAR AND DATES) no | | 16b. SOCIAL SECURITY NO. 579 52 9950 | | 17. INFORMANT ADDRESS Jane Singletary-sister-71 V St., N.W. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SARCOIDOSIS WITH PULMONARY FIBROSIS 350 DUE TO, OR AS A CONSEQUENCE OF (b) LEFT PLEURAL EFFUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY FAILURE | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/9 , 19 83 , to 9/9 , 19 83 , that (I) (we) last saw the deceased alive on 9/9 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE Gerardo M. Gacard | | | | | | DEGREE MD | | 22c. DATE SIGNED 9/13/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARDO M GACARD | | | | | | 22e. ADDRESS 6492 Landoner Rd Landoner MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Sept. 15, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Kelly Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bladensboro, North Carolina | | |
| 24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | |

BP

RESPIRATORY FAILURE

LEFT PLEURAL EFFUSION

SARCOMA OF THE PULMONARY HILUS

BETTY M. WINN

Bellevue

PRINCE GEORGE'S GENERAL HOSP

GENERAL

US

N.C.

PRINCE GEORGE'S COUNTY

SECRETARY

GEORGE

M.

4-25-58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Original. Certificate. Illegible.

1. STATE REGISTRAR FilmG708 2/28/94 kam see Attached!

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 83-25244

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ethel M. Skinner | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 20 83 | | | 2b. HOUR 6:35P M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 30 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD. | | | | |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Mt. Rainier | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS (20712) 3404 Newton Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Jett | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Griffin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-01-3240 | | 17. INFORMANT Percy H. Skinner | | | | ADDRESS Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Left Lower Lobe Pneumonia and Metastatic Neoplasma primary undetermine. DUE TO, OR AS A CONSEQUENCE OF (c) Septicemia, Acute Renal Failure | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0 Recurrent Bleeding Esophageal Varices, Melignant Asites, Advanced Sclerotic Heart Disease, Advanced Athero | | | | | | | | | | |
| 19a. DATE OF OPERATION No | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED No | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) NA | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/22, 1983 to 9/20/1983, that (I) (we) last saw the deceased alive on 9/20, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Sundap | | | | | | DEGREE MD | | | 22c. DATE SIGNED 9/20/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Shrinivas Udapi | | | | | | 22e. ADDRESS 6005 Landover Road, Landover, Md. 20785 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 9-23-83 | | 23c. NAME OF CEMETERY OR CREMATORY Bethel Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | |
| 24. FUNERAL DIRECTOR NAME Nalley's FH., Inc. | | | | | | ADDRESS Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The physician must sign the death certificate, be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove cardstamps. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 - 2 5 2 4 4

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--------------|--|-------------------|--|------------|--|------------|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Ethel | MIDDLE M. | LAST Skinner | 2a. DATE OF DEATH | | MONTH 9 | DAY 20 | YEAR 83 | 2b. HOUR 6:35P | M |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 8 DAY 30 YEAR 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Mt. Rainier | | 14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS (20712) 3404 - Newton Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Jett Maude | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Griffin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 578-0 -3240 | | INFORMANT Percy H. Skinner | | ADDRESS Same as above | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardio-respiratory Failure</u> 4860 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Left Lower Lobe Pneumonia and Metastatic</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Neoplasm, primary undetermined.</u> <u>Septicemia, Acute Renal Failure</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Sclerotic</u> <u>Recurrent Bleeding Esophageal Varices, Malignant Asites, Advanced Atherosclerosis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION NO | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NO | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NA | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/22/1983</u> to <u>9/20/1983</u> , that (I) (we) lost saw the deceased alive on <u>9/20/1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Sundap</u> | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/20/83. | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Shrinivas Udapi | | | | 22e. ADDRESS 6005 Landover Road Landover, MD 20785 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-23-83 | | 23c. NAME OF CEMETERY OR CREMATORY Bethel Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia | | | | | |
| 24. FUNERAL DIRECTOR NAME Nalley's FH, Inc. | | | | ADDRESS Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u> | | | |

BP

alexandria, virginia

General

1-1-72

General

SEP 24 1972

NO. 1000000000

NO. 1000000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | | |
|---|-------------------------|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN A. SLATTERY, Sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 26 83 | | | 2b. HOUR 1:50P |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH DAY MONTH YEAR June 13, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.G. NURSING CARE CENTER | | | 12a. USUAL OCCUPATION (TYPE AND MOST OF WORKING LIFE) Plumber | | 12b. KIND OF BUSINESS OR INDUSTRY Construction |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Prince Geo. | 13c. CITY OR TOWN Landover | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Slattery | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Hilderbrandt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 578 18 7049 | | 17. INFORMANT ADDRESS Dora M. Slattery Same as #13 (Wife) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteremia 3109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Urinary tract infection; Acute decomp DUE TO, OR AS A CONSEQUENCE OF (c) Organic brain syndrome | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1983 to Sept 26 1983 , that (I) (we) lost saw the deceased alive on 9/11/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Robert J. Greige M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/26/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. GREIGE | | | | 22e. ADDRESS 4440 74th Ave Hyattsville MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 9/29/83 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring P.G. Md. | |
| 24. FUNERAL HOME NAME ADDRESS Francis Casch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 28 1983 John J. Connel | | | |

BP

552-1

• **INTERVIEW**

299030 3219-

CHENYI

101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert L Sledd | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 22 83 | | 2b. HOUR 0610 ^A _M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 02 20 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH Riverdale, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber | | 12b. KIND OF BUSINESS OR INDUSTRY Plumbing | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS 5805 42nd Street #210 <i>20781</i> | | |
| 13a. STATE MD | | 13b. COUNTY PG | | 13c. CITY OR TOWN Hyattsville | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Phillip Sledd | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Provose | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unk | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229073700 | | 17. INFORMANT ADDRESS Hospital Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Sepsis</i></u> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF (b) <u><i>malnutrition</i></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <u><i>CVA with Rt. Hemiparesis</i></u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u><i>Arteriosclerotic cardiovascular disease</i></u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u><i>8/19</i></u> , 19 <u><i>83</i></u> , to <u><i>9/21</i></u> , 19 <u><i>83</i></u> , that (I) (we) lost saw the deceased alive on <u><i>9/21</i></u> , 19 <u><i>83</i></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u><i>9/22/83 6:00 AM</i></u> | | | | | | | | | |
| 22b. SIGNATURE <u><i>YK Yoon MD</i></u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u><i>9/22/83</i></u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u><i>YOUNG-KWON H. YOON M.D.</i></u> | | | | 22e. ADDRESS <u><i>5506 Kenilworth Ave. Landon Md</i></u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/26/83 | | 23c. NAME OF CEMETERY OR CREMATORY Westhampton Mem'l Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Richmond, Henrico Co., Va. | | | |
| 24. FUNERAL DIRECTOR NAME Joseph W. Bliley Co. Richmond, Virginia | | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1983 | | 25b. REGISTRAR'S SIGNATURE <u><i>John J. Chief</i></u> | | | |



50% COTTON

Joseph . Miller Co. Richmond, Virginia
500 e. . .
New York, N.Y. and, Harris Co., Pa.
Washington

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|---------------------|
| 1. DECEASED NAME (TYPE OR PRINT) MARIE E SNODGRASS | | | 2a. DATE OF DEATH MONTH DAY YEAR 8 19 83 | | 2b. HOUR 9:37P M |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1906 | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD | | |
| 10. CITY OR TOWN OF DEATH CLINTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator U.S. Govt. | | |
| 13a. STATE Maryland | | 13b. COUNTY Prince George's Forestville | 13c. CITY OR TOWN Forestville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest W. Hagsphil | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriett L. Carter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Thomas W. Snodgrass (Same As #13 A-E) | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive heart failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 wks

DUE TO, OR AS A CONSEQUENCE OF

(b) Atherosclerotic Cardiovascular disease

20 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION N/A | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 18 Aug 83 to 19 Aug 83, that (I) (we) last saw the deceased alive on 19 Aug 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE William J. Oetgen, MD for G.H. Nechman, MD | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 20 Aug 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Oetgen, M.D. | 22e. ADDRESS 3611 Branch Ave Temple Hills, MD 20748 | | |

| | | | |
|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE August 23, 1983 | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland |
|--|------------------------------|--|---|

| | | |
|---|--|---|
| 24. FUNERAL DIRECTOR Lee Funeral Home, Inc. NAME ADDRESS 6638 Old Alexander Ferry Road, Clinton, MD | 25a. DATE REC'D. BY REGISTRAR AUG 26 1983 | 25b. REGISTRAR'S SIGNATURE John J. Smith |
|---|--|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Body released by Dr. Rodriguez

[Faint, illegible text across the page, possibly bleed-through from the reverse side.]



[Vertical text on the right margin, possibly a date or reference number.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMM - 16 50M 4/82
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 2 5 2 4 8 | |
|---|--|---|---|--|---|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Josephine A. Sparacino | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 17 83 2b. HOUR 5:05 a.m. | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 16, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 13a. STATE Maryland | | | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Silver Spring | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gaetano Totaro | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Garufi | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-60-3137 | | 17. INFORMANT Son Joseph A. Sparacino | |
| | | | ADDRESS 123 Eastmoor Drive Silver Spring, Md. 20901 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4039 IMMEDIATE CAUSE (a) <u>RENAL INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PNEUMONITIS; CEREBRAL ISCHEMIA</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 7, 1983</u> to <u>Sept 17, 1983</u> , that (he/she) last saw the deceased alive on <u>Sept 17, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Bernard A. Fitzgerald MD</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-17-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BERNARD A. FITZGERALD</u> | | 22e. ADDRESS <u>217 UNIVERSITY BLVD E, SILVER SPRING MD 20901</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sep. 19, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis J. Collins | | | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | |
| 500 University Blvd., W. Silver Spring, Md. | | | | 25b. REGISTRAR'S SIGNATURE <u>J. C. C.</u> | |

20% COTTON

CHIFFIN



James A. Thompson
Bureau of Agriculture, U.S. Dept. of Agriculture
Washington, D.C.

April 1, 1912

X

Respectfully,
J. A. Thompson

Commissioner of Agriculture
U.S. Department of Agriculture

April 1, 1912

VOIDED DEATH CERTIFICATE NUMBER 83-25249

Michael James Stump - July 11, 1967 - P.G.County

See 1967 Deaths



BP

DHMH - 16 50M 1/81
(VRA 15, 4)

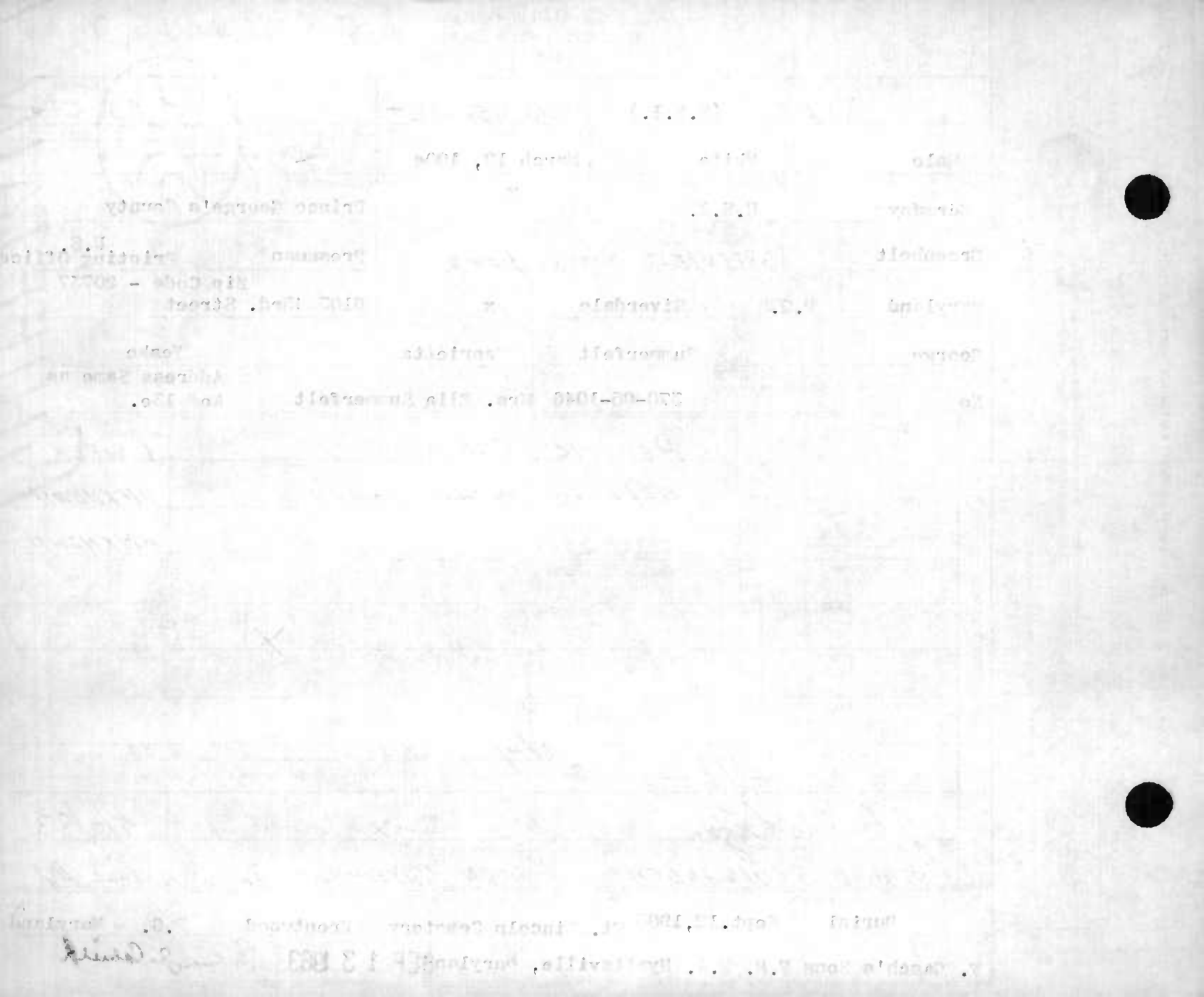
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 25250 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) RYNE (N.M.I.) SUMMERFELT | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 8 83 5 ³⁰ PM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 19, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. IF UNDER 1 YEAR (MONTHS) DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | |
| 10. CITY OR TOWN OF DEATH Greenbelt | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREENBELT NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pressman | | 12b. KIND OF BUSINESS OR INDUSTRY Printing Office | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Riverdale | | 13e. STREET ADDRESS Zip Code - 20737 6103 43rd. Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Summerfelt | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Yeske | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 370-05-1046 | | 17. INFORMANT Mrs. Ella Summerfelt | | ADDRESS Address Same as No# 13e. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOSIS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK UNKNOWN UNKNOWN | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/4/83 to 9/8/83 that (I) (we) lost saw the deceased alive on 9/8 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE J. Reinschagen | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/8/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERALD REINSCHAGEN | | | | 22e. ADDRESS 4404 QUEENSBURY RD RIVERDALE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept. 12, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | | 23e. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) SEP 13 1983 | |
| 24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Maryland | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|---|---|--|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) HILDA L. SYPKENS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 4 83 | | | 2b. HOUR 4 ¹⁵ PM | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR December 22, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEO. NURSING CARE CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Presser | | 12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Davidsonville | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3823 Birdsville Road 21035 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lewis Gehrig | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMATION 552-07-2517 | | Bruce Sypkens - Same As #13 A-E | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2080 Acute leukemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 1, 19 83, to SEPT. 4, 19 83, that (I) (we) last saw the deceased alive on SEPT 3, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 9/4/83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NELSON G. GOODMAN, MD. | | | | | 22e. ADDRESS 3231 SUPERIOR LN, #A7 BOWIE, MD 20715 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE September 5, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Prince George's MD | | | |
| 24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS Old Alexander Ferry Road, Clinton, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1983 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

BP



PRINCE GEORGE'S COUNTY

PRINCE GEO. NURSING CARE CENTER

CHEVERLY



11/11/72

NOV 11 1972



NELSON & GOODMAN, MD.

3031 SUPERIOR LANE, SUITE 101, MD 20712

11/11/72

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25252

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|---------|---|--|---|--|---|--|----------------------------|--|--------------------------------|--|--------------------------------------|--|---------|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Robert Henry Taliaferro | | | | | | | | 9-15-83 | | 19 | | 83 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Male | White | Dec. 1, 1900 | | 82 YRS. | | | | | | 9-21 | | 19 | | 83 | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | MD. | |
| Virginia | | U.S.A. | | | | | | | | | | Prince Georges County | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Forestville | | 2020 Brooks Drive, Apt 326 | | U.S. MARINES | | Retired | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Georges | | Forestville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2020 Brooks Drive | | Apt. 326 | | | | | | | |
| 14. FATHER'S NAME | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | | | |
| Charles D. Taliaferro | | | | | | | | Emma | | | | | | Decatur | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| Yes | | Peacetime | | 577-30-6682 | | Brother: James Taliaferro, Annandale, Va. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | 4292 IMMEDIATE CAUSE (a) | | Sudden cardiac death | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | * APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. | | Deputy | | MEDICAL EXAMINER | | DATE SIGNED | | 9-21-83 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Augusto P. Rodriguez, M.D. | | ADDRESS | | 5009 Rayburn Ct., Temple Hills, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 9-25-83 | | Aquia Epis. Church Cem. | | Stafford County, Va. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | Wheeler & Thompson, Inc. | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Fredericksburg, Va. | | | | SEP 29 1983 | | John J. Smith | | | | | | | | | | | |

Dec. 1, 1900

X

Virginia

Prince George County

Sealed

U. S. MARSHAL

John

Georgia

Georgia

Georgia

x 2000 (book alive)

Sealed

John

Initials

John

receiving

17-2-1002

Robert: James Talbot, Annandale, Va.

Station County, Va.

John Talbot

17-2-1002

John

Robert: James Talbot, Annandale, Va.

Station County, Va.

John Talbot

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 2 5 2 5 3 REG. NO. | |
|---|--|----------------------|--|---|--|--|--|---|--|--------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN FRANKLIN <i>Tayman</i> | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. DATE OF DEATH | | 2c. DATE OF DEATH | |
| 3. SEX male | | 4. RACE White | | 5. DATE OF BIRTH Nov. 6, 1915 | | 6. AGE (IN YEARS) 67 | | 7. IF UNDER 1 YR. MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's | | |
| 10. CITY OR TOWN OF DEATH Upper Marlboro | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Geo's General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Liquor Store Manager | | | 12b. KIND OF BUSINESS OR INDUSTRY Private Owned Liquor Store | | |
| 13a. STATE Maryland | | | 13b. COUNTY Pr. Geo's | | | 13c. CITY OR TOWN Upper Marlboro | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME Charles | | | 15. MOTHER'S MAIDEN NAME Rose Ella Thomas | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 579-22-0055 | | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myo Cardial infarct 1579 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) dx of Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c) | | | 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myo Cardial infarct 1579 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) dx of Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c) | | | 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myo Cardial infarct 1579 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) dx of Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c) | | | 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myo Cardial infarct 1579 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) dx of Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c) | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Sgt. A. DARRIN | | | | TITLE (SPECIFY) Dep't | | | | DATE SIGNED 9-11-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis Rd. Bladensburg MD 20710 | | | | ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9/15/83 | | | | 23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem. | | | |
| 23d. LOCATION CITY OR TOWN Suitland (Pr. Geo's) | | | | 23e. COUNTY Pr. Geo's | | | | 23f. STATE Md. | | | |
| 24. FUNERAL DIRECTOR Richard A. Coleman | | | | 24. FUNERAL HOME Upper Marlboro, Maryland 20772 | | | | 25. DATE REC'D. BY REGISTRAR SEP 15 1983 | | | |
| 25. REGISTRAR'S SIGNATURE John J. Lohr | | | | 25. REGISTRAR'S SIGNATURE | | | | | | | |

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948



1947-1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for burial papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH | | | DAY | | | YEAR | | | 2b. HOUR | | |
| GLADYS RUTH TEABOLDT | | | SEPTEMBER 1, 1983 | | | | | | | | | 3:54P M | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS | | |
| FEMALE | | | WHITE | | | FEBRUARY 19, 1913 | | | 70 | | | YRS. | | | MONTHS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| MICHIGAN | | | UNITED STATES | | | | | | PRINCE GEORGE'S COUNTY MD | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| ANDREWS AFB | | | MALCOLM GROW USAF MEDICAL CENTER | | | TEACHER | | | EDUCATION | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | |
| VIRGINIA | | | FAIRFAX | | | ALEXANDRIA | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 3902 TOWANDA ROAD 22303 | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | |
| SAMUEL SCHULTZ | | | LOLA BERNICE ALLEN | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | | | | | |
| NO | | | 230-54-4335 | | | JULIE DETWILER | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> RESPIRATORY ARREST | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) <u>lymphomatous spread of left breast carcinoma</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1 Sept</u> , 19 <u>83</u> , to <u>1 Sept</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>1 Sept</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | |
| <u>Kurt Harding</u> | | | DO | | | | | | 1 Sept 83 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| KURT HARDING | | | MALCOLM GROW USAF MED CEN AAFB, MD 20331 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | COUNTY | | | STATE | | |
| Burial | | | 9-6-83 | | | Arl. Nat. Cemetery | | | Arlington | | | Va. | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| NAME | | | ADDRESS | | | | | | | | | | | | | | |
| Everly-Wheatley Funeral Home | | | Alex., Va 22302 | | | SEP 7 1983 | | | | | | | | | | | |

MEMORANDUM FOR THE CHIEF OF STAFF

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|---|--|---|---|--|---|---------------------------------|--|--|
| 1 - FOR STATE REGISTRAR | | | REG. NO. 25255 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | |
| MARY E THOMAS | | | SEPTEMBER 13, 1983 | | | | 3:30 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | BLACK | 5 10 1909 | | 74 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | | PRINCE GEORGES COUNTY, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| LAUREL | GREATER LAUREL BELTSVILLE HOSPITAL | | | Unemployed | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | | | |
| MARYLAND Pr. Georges LAUREL | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3580 Whiskey Bottom Rd. 20707 | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | ADDRESS | | | |
| ARTHUR EDWARDS | | | MARCIA | | | UNKNOW | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| NO | | | 217-24-8121 | | Doretha Thomas | | 3580 Whiskey Bottom Laurel, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST. | | | | | | | | | |
| 5733 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE HEPATIC FAILURE. | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLE HEPATITIS. | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | | 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-8-83, to 9-13-83, that (I) (we) last saw the deceased alive on 9-13-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| M.H. CHAUDHRY, M.D. | | | M.D. | | | | 9-13-83 | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK #) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Burial | | | 9-16-83 | | MT. ZION CEM. | | LAUREL Pr. Geo's Md. | | |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | REGISTRAR'S SIGNATURE | | | | |
| GEORGE R. SNOWDEN | | | 246 N. Wash. St. Rockville, Md. | | SEP 15 1983 John J. Ganiel | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| RICHARD Edward THOMAS SR | | | | 9 30 83 | | | | 8:25P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7b. IF UNDER 24 HRS. | |
| Male | | Caucasian | | July 11, 1919 | | 64 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Washington, DC | | USA | | | | PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CLINTON | | SOUTHERN MARYLAND HOSPITAL CENTER | | | | Route Salesman | | Crusty Pie Co. | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | | | Pr. George's | | Clinton | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8309 Schultz Road (20735) | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Henry Edward Thomas | | | | Margaret E. Kaiser | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | |
| Yes | | | | WWII | | Margaret E. Thomas | | Same As #13 A-E | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 4254 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiomyopathy</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>04/13/83</u> , 19 <u>83</u> , to <u>09/30/83</u> , 19 <u>83</u> , that (I/we) last saw the deceased alive on <u>09/30/83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Rafael Lee</u> | | | | | | DEGREE <u>MD</u> | | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>9-30-81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Lee, MD | | | | | | 22e. ADDRESS 9410 Brandywine Rd., Clinton, Md. 20735 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | October 4, 1983 | | Mt. Olivet Cemetery | | Washington, DC | | | |
| 24. FUNERAL DIRECTOR Lee Funeral Home, Inc. Old Alexander Ferry Road, Clinton, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 6 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Givich</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



POX COLLEGE

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

25251

 1. FOR
 STATE
 REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Bernard E. Thompson | | | 2a. DATE OF DEATH MONTH 9 DAY 30 YEAR 83 | | 2b. HOUR 11:55 M |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH 10 DAY 2 YEAR 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 51 | IF UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Cr MD. | |
| 10. CITY OR TOWN OF DEATH Clinton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Construction |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. CITY OR TOWN Charles | 13c. CITY OR TOWN Waldorf | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME 14a. FIRST Walter | | 14b. MIDDLE Charles | 14c. LAST Thompson | 15. MOTHER'S MAIDEN NAME 15a. FIRST Elizabeth | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-26-4805 | 17. INFORMANT Elizabeth Thompson ADDRESS SAH Metzenberger | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell cancer of larynx with metastasis 1449 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from April , 19 83 to Sept , 19 83 , that (I) (we) last saw the deceased alive on 8-30 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kai-Yin Yung, MD | | DEGREE | | 22c. DATE SIGNED 10-1-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Yung, MD | | 22e. ADDRESS 6525 Belcrest Rd # 460 Hyattsville, MD 20782 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10/4/83 | 23c. NAME OF CEMETERY OR CREMATORY MD Veterans | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md |
| 24. FUNERAL DIRECTOR NAME Marcell Adams | | ADDRESS Cheveruse Rd | | 25a. DATE REC'D. BY REGISTRAR OCT 14 1983 | |
| | | | | REGISTRAR'S SIGNATURE John J. Gurnea | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 differs from any injury, or other traumatic event, the medical examiner must be notified at once.

7.11.2012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|---|---------------------------------------|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HORACE J. THOMPSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 9 23 83 | | | 2b. HOUR 1:15AM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1909 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Tech. | | 12b. KIND OF BUSINESS OR INDUSTRY John Hopkins University | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Prince Geo. | | 13c. CITY OR TOWN Greeneblt | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6 Greendale Place 20770 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur C. Thompson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie King | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 09 8423 | | 17. INFORMANT ADDRESS Eleanor G. Thompson Same as #13 (Wife) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4590 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SHOCK DUE TO MASSIVE HEMORRHAHE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) FROM AORTO-ENTERIC FISTULA POSS. DUE TO ABSCESS | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PREVIOUS HISTORY OF CARDIAC DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION SEPT 24 83 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EMERGENCY HEMORRHAHE | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) SPONTANEOUS FISTULA DUE TO ABSCESS | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/21/83 , 19 83 , to 9/22 19 83 , that (I) (we) last saw the deceased alive on 9/22 , 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Steven Guillory M.D. | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 9/24/83 | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN GUILLORY, M.D. | | | | 22f. ADDRESS ONE HOSPITAL DR. #72 CHEVERLY, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL METHOD Burial | | 23b. DATE 9/26/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | | | 23d. LOCATION COUNTY Brentwood P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | | | | | | | | |

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MAC: 1 1 13 12

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5500-00-21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

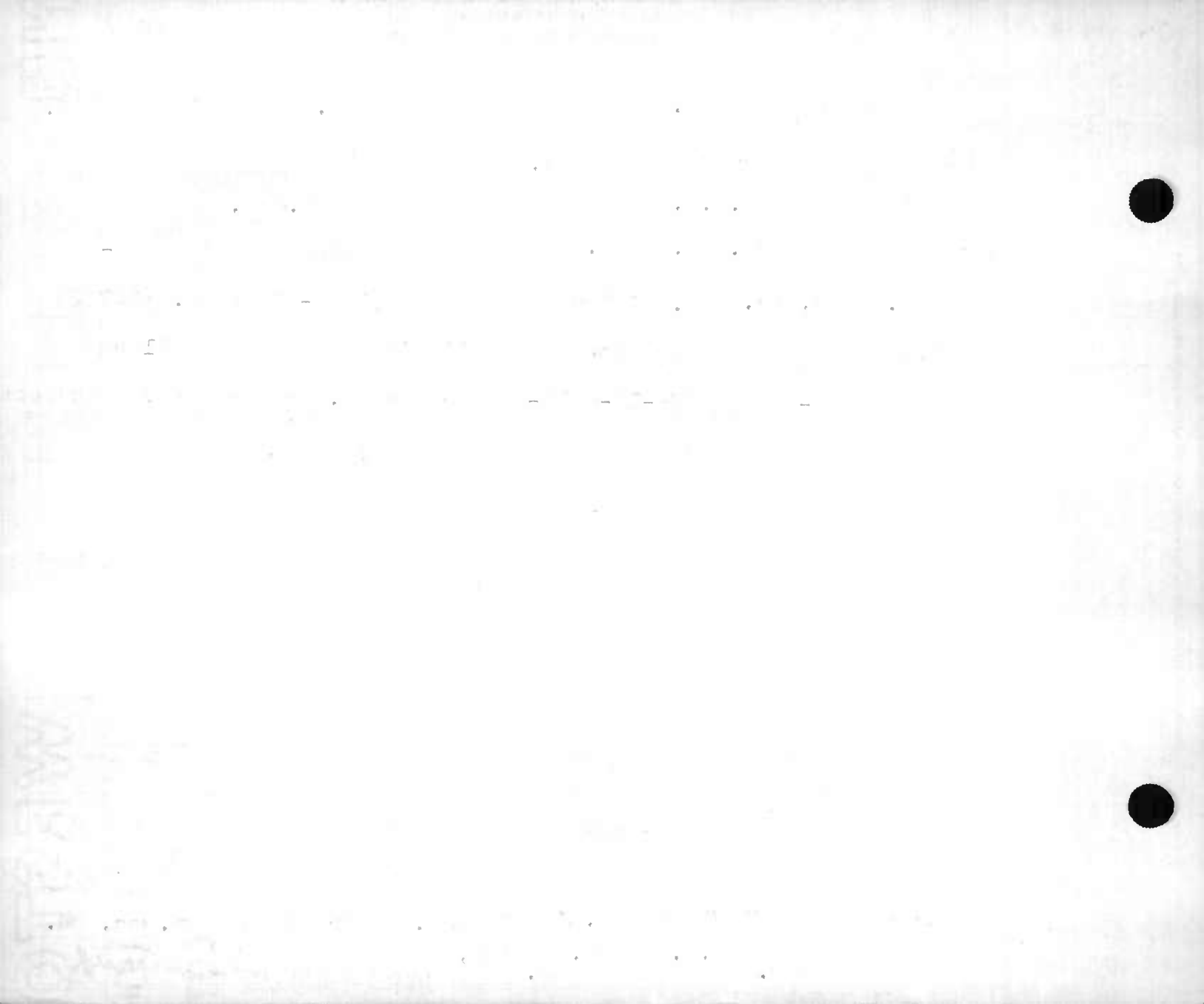
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRS 15, 4) 7/78

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Jesse | | MIDDLE J. | | LAST Thompson | | 2a. DATE OF DEATH MONTH DAY YEAR Sep. 8 1983 | | 2b. HOUR 6:10 P.M. | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 25 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pr. Geo. Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE Md. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Mt. Rainier | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4307 - 30th St. (20712) | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Thompson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Clark | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - | | 17. INFORMANT ADDRESS 579-10-6613-A Margaret V. Thompson (above address (Wife)) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute on Chronic Respiratory Failure</u> 3400 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Muscular Dystrophy</u> (c) <u>Chronic Obstructive Airway Dis.</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19 76</u> , to <u>9-8</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9-8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Surbh C. Gupta</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 9-9-83 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURBH C. GUPTA MD. | | | | 22e. ADDRESS 3503 Perry St. Mt. Rainier, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/12/1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. | | ADDRESS Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 14 1983 | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u> | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|---|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edward 7. Thornberg Sr | | | 2a. DATE OF DEATH MONTH DAY YEAR September 24, 1983 | | 2b. HOUR 7:20P M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH July 17 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Hub Furniture | |
| 13a. STATE Maryland | | 13b. COUNTY Pr. Georges | | 13c. CITY OR TOWN Beltsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph F. Thornberg | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Masters | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A | |
| 17. INFORMANT Ruth N. Thornberg, - wife- (same as 13c) | | ADDRESS 3105 Craiglawn Road 20705 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm 4413 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Cleaved by Med Examiner | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Feb. 12, 1983 , to Feb. 12, 1983 , that (I) (we) lost saw the deceased alive on Feb. 12, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joseph F. Schramm MD | | | | DEGREE | | 22c. DATE SIGNED 9/25/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph F. Schramm MD | | | | 22e. ADDRESS 2118 N. H. Ave., Silver Spring, Md. | | | |

| | | | | | | | |
|--|--|-------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL SPEC Burial | | 23b. DATE 9-27-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Funeral Home Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 29 1983 | | 25b. REGISTRAR'S SIGNATURE Joseph F. Schramm MD | |

Cleared by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mary ALICE TINSLEY | | | 2a. DATE OF DEATH MONTH DAY YEAR September 13, 1983 | | | 2b. HOUR 10:21a_M | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Apr. 7, 1882 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 101 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 101 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD | | | |
| 10. CITY OR TOWN OF DEATH Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY At home | |
| 13a. STATE D.C. | | 13b. COUNTY Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS 615 Tuckerman St. N.W. 99999 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Wade | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clory Warren | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Collins Funeral Home, Bassett, Va. | | | |

| | | | |
|---|--|--|--|
| 11. CAUSE OF DEATH (Enter only one cause for part I, the immediate cause) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4161 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Bleeding gastric ulcer, acute diverticulitis, Aortic Aneurysm

| | | | | | | | |
|------------------------|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|---|--|--|--|

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
|---|--|--|--|--|--|--|--|

| | | | | | |
|---|--|--|--|---|--|
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE | |
|---|--|--|--|---|--|

| | |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12/83 to 9/13/83 , that (I) (we) lost 9/13/83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | |
|---|--|

| | | | | | |
|---|--|--------|--|------------------------------------|--|
| 22b. SIGNATURE Michael R. Farzin MD | | DEGREE | | 22c. DATE SIGNED 9-13-83 | |
|---|--|--------|--|------------------------------------|--|

| | | | |
|---|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FARZIN MEMDI P. | | 22e. ADDRESS 6201 Greenbelt Rd - College Park Md 20740 | |
|---|--|--|--|

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-17-83 | | 23c. NAME OF CEMETERY OR CREMATORY Tinsley Family Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rocky Mount, Va. | |
|--|--|-----------------------------|--|--|--|---|--|

| | | | | | | | |
|--|--|-----------------------------------|--|---|--|---|--|
| 24. FUNERAL DIRECTOR NAME Everly-Wheatley | | ADDRESS Alexandria, Va. | | 25a. DATE REC'D. BY REGISTRAR SEP 22 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Cahill | |
|--|--|-----------------------------------|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Maxine J. Todd | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 24 83 | | 2b. HOUR 0810 PM |
| 3. SEX F | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR DEC 25 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH P.G. MD. | | |
| 10. CITY OR TOWN OF DEATH Riverdale M.D. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LELAND MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY LABOR RELATIONS |
| 13a. STATE MD | 13b. COUNTY P.G. | 13c. CITY OR TOWN COLLEGE PARK | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 9129 AUTOVILLE DR. 20740 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JACKSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL TUCKER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS GEORGE A. TODD SAME AS 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ACUTE MYOCARDIAL INFARCTION one day DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-23, 1983, to 9-24, 1983, that (I) (we) last saw the deceased alive on 9/24/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE K. J. Mathew MD | | | | 22c. DATE SIGNED 9/24/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. J. MATHEW | | | | 22e. ADDRESS 3700 EAST WEST HIGHWAY HYATTSVILLE, MD 20782 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE SEPT 27 1983 | 23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEM | | 23d. LOCATION CITY OR TOWN COUNTY STATE ADELPHI P.G. MD |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS 500 UNIV. BLVD. WEST, SILVER SPRING, MD 20901 | | | 25a. DATE REC'D BY REGISTRAR SEP 29 1983 | | |

BP

CONFIDENTIAL

SECRET

CONFIDENTIAL



Medical Examiner Notified & Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Alba (N.M.I.) Tos | | | 2a. DATE OF DEATH MONTH DAY YEAR September 29, 1983 | | | 2b. HOUR 12:30A | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR February 10, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | |
| 10. CITY OR TOWN OF DEATH Beltsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11605 35th. Place | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Beltsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11605 35th. Place 20705 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Achille Viana | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annetta Pezzaro | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 578-03-8853 | | 17. INFORMANT Mrs. Barbara A. Jenkins | | ADDRESS Address Same as | | No# 13e. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) parkinsons disease 3320 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) cardio respiratory failure. (c) Septicemia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/11 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/11 1983 to 9/11 1983 , that (I) (we) lost saw the deceased alive on 9/11 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE M. Shukla | | | | DEGREE MD | | | | 22c. DATE SIGNED Sept. 29, 1983 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mushtaq Ahmad Shah, M.D. | | | | 22e. ADDRESS 4637 Eastern Ave. Mt. Rainier, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Oct. 1, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH A. TRIMMER | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 03 83 | | 2b. HOUR 9:00 AM |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR June 15 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 13a. STATE Maryland | | 13b. COUNTY Prince Georges | 13c. CITY OR TOWN Bowie | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 8417 Church Lane 20715 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward D. Trimmer | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deliah Garrett | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 717-07-7940 | 17. INFORMANT ADDRESS Joseph E. Trimmer 7326 Finns Lane Lanham, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERITONITIS - SEPSIS</u> 5679 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-1</u> , 19 <u>83</u> , to <u>9-3</u> , 19 <u>83</u> , that (we) last saw the deceased alive on <u>9-3</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Barry H. Epstein</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-3-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry H. Epstein MD | | 22e. ADDRESS 6201 Greenbelt Rd., College Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept 6 1983 | 23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE York, Pennsylvania |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home | | ADDRESS 16000 Annapolis Rd. Bowie, Md. | | 25a. DATE REC'D. BY REGISTRAR SEP 7 1983 | |
| 25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i> | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 1, 2, AND 3 TO THE FUNERAL HOME. IF ANY DELAY IS NECESSARY, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25265 | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Bobby | | MIDDLE | | LAST Troy | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 3. SEX M | | 4. RACE Black | | 5. DATE OF BIRTH 7-26-45 | | 6. AGE (IN YEARS) 38 YRS. | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEATH 9 18 1983 | |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE CITY OR COUNTY OF DEATH | | Prince George's County, MD. | | 2d. HOUR 4:42 | |
| 10. CITY OR TOWN OF DEATH Hillcrest Hghts. | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3001 Branch Avenue, #302 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTENDANT | | 12b. KIND OF BUSINESS OR INDUSTRY Day Care | | | | | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN Prince George | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 3001 BRANCH AVE APT 302 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARITTE TROY | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES VIETNAM | | 16b. SOCIAL SECURITY NO. 241 72 8641 | | 17. INFORMANT ADDRESS MAURICE F.H. HUMBERT N.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5718 Fatty Liver Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth M.D. | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 9-21-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 9/26/83 | | 23c. NAME OF CEMETERY OR CREMATORY Elizabeth Hight Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | Cumberland N.C. | | | |
| 24. FUNERAL DIRECTOR NAME Joseph C. Luss | | ADDRESS 2222 W North Ave | | 25a. DATE REC'D. BY REGISTRAR OCT 3 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Luss | | | | | |

[Faint, mostly illegible handwritten text covering the majority of the page, likely a survey or land management report.]



[Vertical handwritten text, possibly a signature or date, oriented sideways.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Item 2a, Film#G583 - 83 2 5 2 6 6

FOR 9-30-83 jlb
1. STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) *TRUSSSELL* Mildred *First* Grace Trussell

2. DATE OF DEATH *September 17, 1983* *September 15, 1983* 3:50 PM.

3. SEX *F* Female 4. RACE *W* Caucasian 5. DATE OF BIRTH *1/3/1920*

6. AGE (IN YEARS LAST BIRTHDAY) *63* YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) *Pennsylvania* 7b. CITIZEN OF WHAT COUNTRY? *U.S.A.* 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH *Prince George's County, MD.*

10. CITY OR TOWN OF DEATH *Clinton* 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) *Clinton Conv. Center*

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) *Nursing Assistant* 12b. KIND OF BUSINESS OR INDUSTRY *Nursing*

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE *MD.* 13c. COUNTY *Charles* 13d. CITY OR TOWN *WHITE PLAINS* 13e. INSIDE CITY LIMITS? YES ☐ NO ☒ 13f. STREET ADDRESS *Post Office Box 103 (20695)*

14. FATHER'S NAME FIRST MIDDLE LAST *Edward Mc Culland* 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST *Mable Schwartz*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) *No* 16b. SOCIAL SECURITY NO. *212-22-1954* 17. INFORMANT *Highway 228, Box 154 Waldorf, Maryland 20601*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Cardiovascular disease*
2500 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) *Arteriosclerosis*
(c) *Diabetes*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *None*

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 *83* 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from *9/17* 19 *83*, to *9/17* 19 *83*, that (I) (we) last saw the deceased alive on *9/17* 19 *83*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE *R. C. ZANOSTA* DEGREE *MD* 22c. DATE SIGNED *9/23/83*

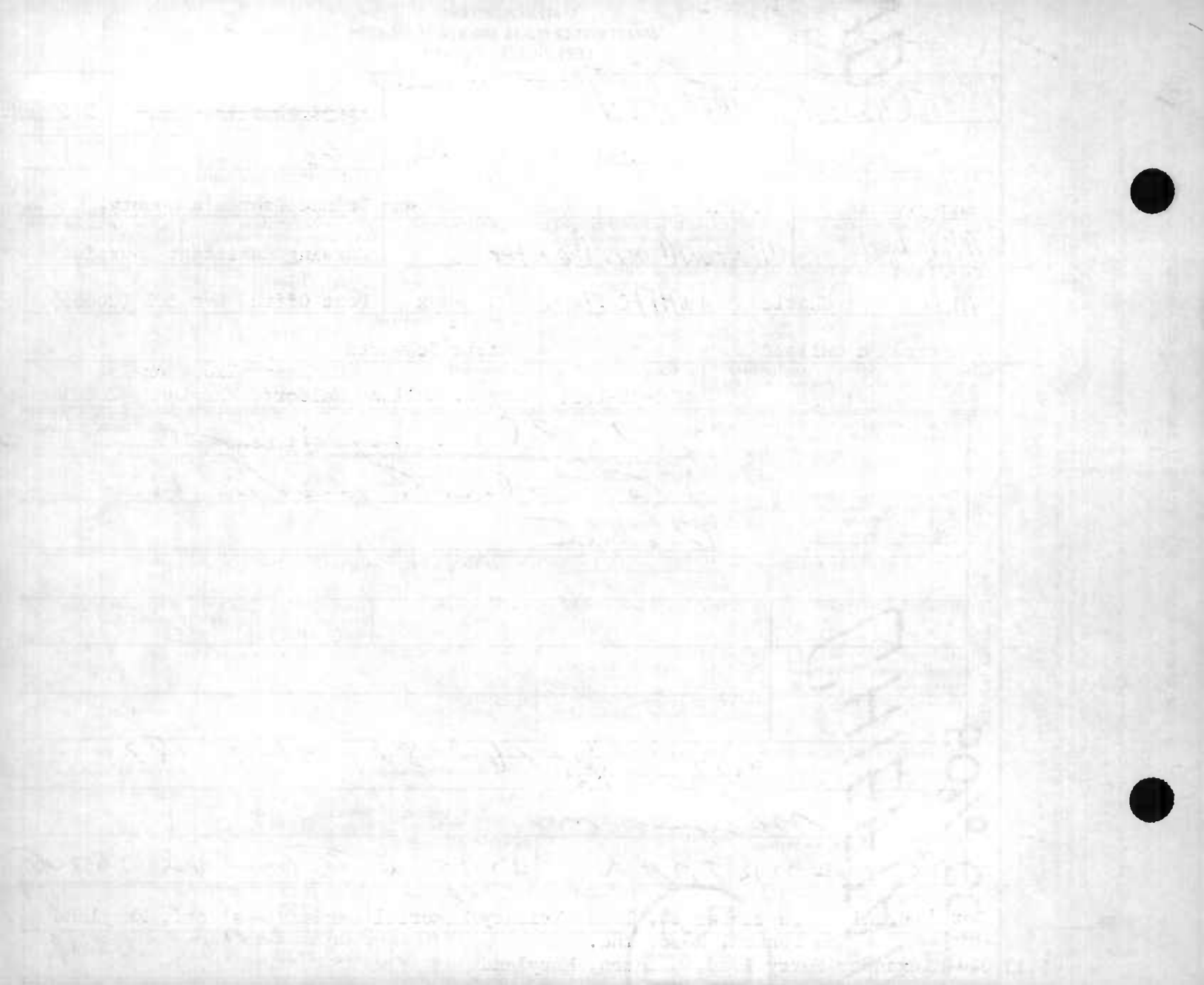
22d. PHYSICIAN'S NAME (TYPE OR PRINT) *R. C. ZANOSTA* 22e. ADDRESS *4235 N. W. 20th Ave. Md 20746*

23a. BURIAL, CREMATION, REMOVAL *Burial* 23b. DATE *September 20, 1983* 23c. NAME OF CEMETERY OR CREMATORY *Trinity Memorial* 23d. LOCATION CITY OR TOWN COUNTY STATE *Gardens Waldorf, Maryland*

24. FUNERAL DIRECTOR *Lee Funeral Home, Inc.* 25a. DATE REG'D. BY REGISTRAR *SEP 23 1983* 25b. REGISTRAR'S SIGNATURE *John J. [Signature]*

Old Alexander Ferry Road, Clinton, Maryland

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH 1972 FILES, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25267 | |
|--|--|------------------|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Julius Tymm | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 9 1 19 83 | | 7b. HOUR 3:31 AM | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1896 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 1 19 83 | |
| 7a. BIRTHPLACE (STATE OR TERRITORY OR COUNTRY) Pennsylvania | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY US Navy Yard | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | | 13b. CITY OR TOWN Prince Georges Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5031 55th. ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gabriel Tymm | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Tymm | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | (IF YES, GIVE WAR OR DATES) Korean | | 16b. SOCIAL SECURITY NO. 579-58-2720 | | 17. INFORMANT ADDRESS Anna Lucille Tymm-wife-(same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE SAID A DAER M | | | | | | TITLE (SPECIFY) M.D. Deputy | | MEDICAL EXAMINER | | DATE SIGNED 9-1-83 | |
| EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis Rd. | | | | | | ADDRESS Bladensburg MD 20710 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 9-6-1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Georges Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 2 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |

• **DM**

125103

Annex Exhibit Type-4(a)-(same as 13a)

Prince Georges Harbour

2003 • J. Neurosci., July 23, 2003 • 23(30):7911–7920 • 7915

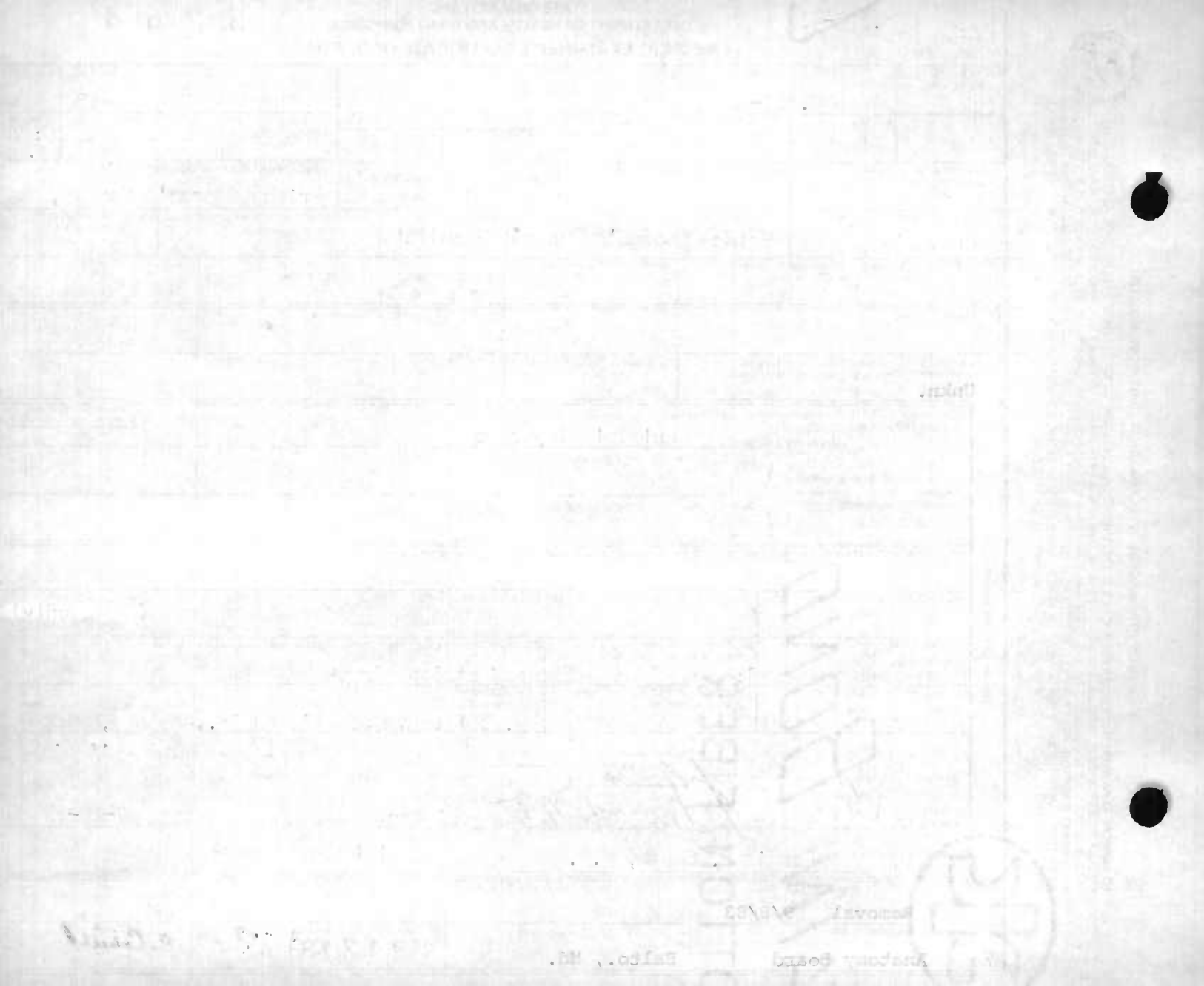
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | |
|---|--|------------------|--|--|--|--------------------------------------|--|---|--|---|--|--|--|--|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 25268 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST UNK.#83-42 | | | | | | | | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 7 9 1983 | | 2b. HOUR 9:06 a.m. | | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 9 1983 | | 2d. HOUR 9:06 a.m. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince George's General Hospital | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| Unkn. | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 7b. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:30 p.m. 7 9 1983 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) pedestrian struck by auto | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road | | | | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) Rt. 301 south of Clifton Dr., Newburg, Prince George's Co., Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, hereinafter, and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dennis F. Smyth, M.D. | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 7-10-83 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | | 23b. DATE 9/8/83 | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) | | | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 13 1983 | | | | 25b. REGISTRAR'S SIGNATURE e. Chisel | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | REG. NO. | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---------------------|--|-----------------|--|-------|--|------|--|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| IDA | | | | | | VAINER | | SEPTEMBER 23, | | 1983 | | 10:25 | | PM | | M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | | |
| FEMALE | | WHITE | | JANUARY 5, 1900 | | 83 | | MONTHS | | DAYS | | HOURS | | MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| ROUMANIA | | U.S.A. | | | | PRINCE GEORGE'S COUNTY | | | | | | | | | | MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| CHEVERLY | | PRINCE GEORGE'S COUNTY GENERAL HOSPITAL | | CHEFS COOK | | DIETICIAN | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | | |
| MARYLAND | | PRINCE GEORGE'S | | HYATTSVILLE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6721 25th AVENUE | | | | | | | | 20748 | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| PINCUS | | RAPPAPORT | | PEARL | | COHEN | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | | | | | |
| NO | | 197-32-1168A | | OTILIA LEVI, | | 6721 25th AVENUE | | | | | | | | | | WEST HYATTSVILLE, MARYLAND | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 0389 | | CARDIO-PULMONARY-ARREST | | | | 4 DAYS | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO, OR AS A CONSEQUENCE OF | | (b) | | 4 DAYS | | | | | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| | | P.M. | | 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that (I) <input checked="" type="checkbox"/> (myself) attended the deceased from <u>JUNE 8</u> , 19 <u>83</u> , to <u>SEPT. 23</u> , 19 <u>83</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>SEPT. 23</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | | | | |
| DR. DAVID S. SCHACHTER, M. D. | | | | 9/24/1983 | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | | | |
| | | 115 CENTERWAY | | | | | | | | | | | | | | | |
| | | GREENBELT, MARYLAND | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| BURIAL | | 9/26/1983 | | JUDEAN MEMORIAL GARDENS | | OLNEY, MONTGOMERY, MARYLAND | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | SEP 27 1983 | | John J. Canine | | | | | | | | | | | | | |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | | | | | | | | | | | | | |

Handwritten notes and tables on lined paper. The text is mostly illegible due to fading and bleed-through. Some visible fragments include:

TABLE 1

| DATE | TIME | LOCATION | REMARKS |
|----------|-------|----------|---------|
| 10/10/50 | 10:00 | ... | ... |
| 10/10/50 | 10:15 | ... | ... |
| 10/10/50 | 10:30 | ... | ... |
| 10/10/50 | 10:45 | ... | ... |
| 10/10/50 | 11:00 | ... | ... |
| 10/10/50 | 11:15 | ... | ... |
| 10/10/50 | 11:30 | ... | ... |
| 10/10/50 | 11:45 | ... | ... |
| 10/10/50 | 12:00 | ... | ... |
| 10/10/50 | 12:15 | ... | ... |
| 10/10/50 | 12:30 | ... | ... |
| 10/10/50 | 12:45 | ... | ... |
| 10/10/50 | 13:00 | ... | ... |
| 10/10/50 | 13:15 | ... | ... |
| 10/10/50 | 13:30 | ... | ... |
| 10/10/50 | 13:45 | ... | ... |
| 10/10/50 | 14:00 | ... | ... |
| 10/10/50 | 14:15 | ... | ... |
| 10/10/50 | 14:30 | ... | ... |
| 10/10/50 | 14:45 | ... | ... |
| 10/10/50 | 15:00 | ... | ... |
| 10/10/50 | 15:15 | ... | ... |
| 10/10/50 | 15:30 | ... | ... |
| 10/10/50 | 15:45 | ... | ... |
| 10/10/50 | 16:00 | ... | ... |
| 10/10/50 | 16:15 | ... | ... |
| 10/10/50 | 16:30 | ... | ... |
| 10/10/50 | 16:45 | ... | ... |
| 10/10/50 | 17:00 | ... | ... |
| 10/10/50 | 17:15 | ... | ... |
| 10/10/50 | 17:30 | ... | ... |
| 10/10/50 | 17:45 | ... | ... |
| 10/10/50 | 18:00 | ... | ... |
| 10/10/50 | 18:15 | ... | ... |
| 10/10/50 | 18:30 | ... | ... |
| 10/10/50 | 18:45 | ... | ... |
| 10/10/50 | 19:00 | ... | ... |
| 10/10/50 | 19:15 | ... | ... |
| 10/10/50 | 19:30 | ... | ... |
| 10/10/50 | 19:45 | ... | ... |
| 10/10/50 | 20:00 | ... | ... |
| 10/10/50 | 20:15 | ... | ... |
| 10/10/50 | 20:30 | ... | ... |
| 10/10/50 | 20:45 | ... | ... |
| 10/10/50 | 21:00 | ... | ... |
| 10/10/50 | 21:15 | ... | ... |
| 10/10/50 | 21:30 | ... | ... |
| 10/10/50 | 21:45 | ... | ... |
| 10/10/50 | 22:00 | ... | ... |
| 10/10/50 | 22:15 | ... | ... |
| 10/10/50 | 22:30 | ... | ... |
| 10/10/50 | 22:45 | ... | ... |
| 10/10/50 | 23:00 | ... | ... |
| 10/10/50 | 23:15 | ... | ... |
| 10/10/50 | 23:30 | ... | ... |
| 10/10/50 | 23:45 | ... | ... |
| 10/10/50 | 24:00 | ... | ... |

SEP 27 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|-----------------------------------|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HERBERT WILLIAM VANDERSALL | | | 2a. DATE OF DEATH MONTH DAY YEAR September 15, 1983 | | | 2b. HOUR 7:00 a.m. | | | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR April 22, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH LANHAM | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY University | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Pr George's | | 13c. CITY OR TOWN Bowie | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 12316 Skylark Lane 20715 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elias Wesley Vandersall | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myra E. Kling | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 1 | | | |
| 16b. SOCIAL SECURITY NO. 192-26-7924 | | | | 17. INFORMANT Mrs. Neva G. Vandersall | | | | ADDRESS 12316 Skylark Lane Bowie, MD 20715 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest 4360 DUE TO, OR AS A CONSEQUENCE OF: (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (c) cerebrovascular accident | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 d. 5 d. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) diabetes ; gastrointestinal bleedng. | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) — | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1978 , 19 Sept. 15 , 19 83 , that (I) (we) last saw the deceased alive on Sept. 14 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE David A. Boetcher, M.D. | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 9-15-83 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID A. BOETCHER, M.D. | | | | | | 22e. ADDRESS 14300 Gallant Fox Lane, Bowie, Md. 20715 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE Sept. 16, 1983 | | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Pr George's, MD | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home | | | | | | ADDRESS 16000 Annapolis Road Bowie, Maryland 20715 | | | 25a. DATE REC'D BY REGISTRAR SEP 21 1983 | | |
| 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | | | | | | | |

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

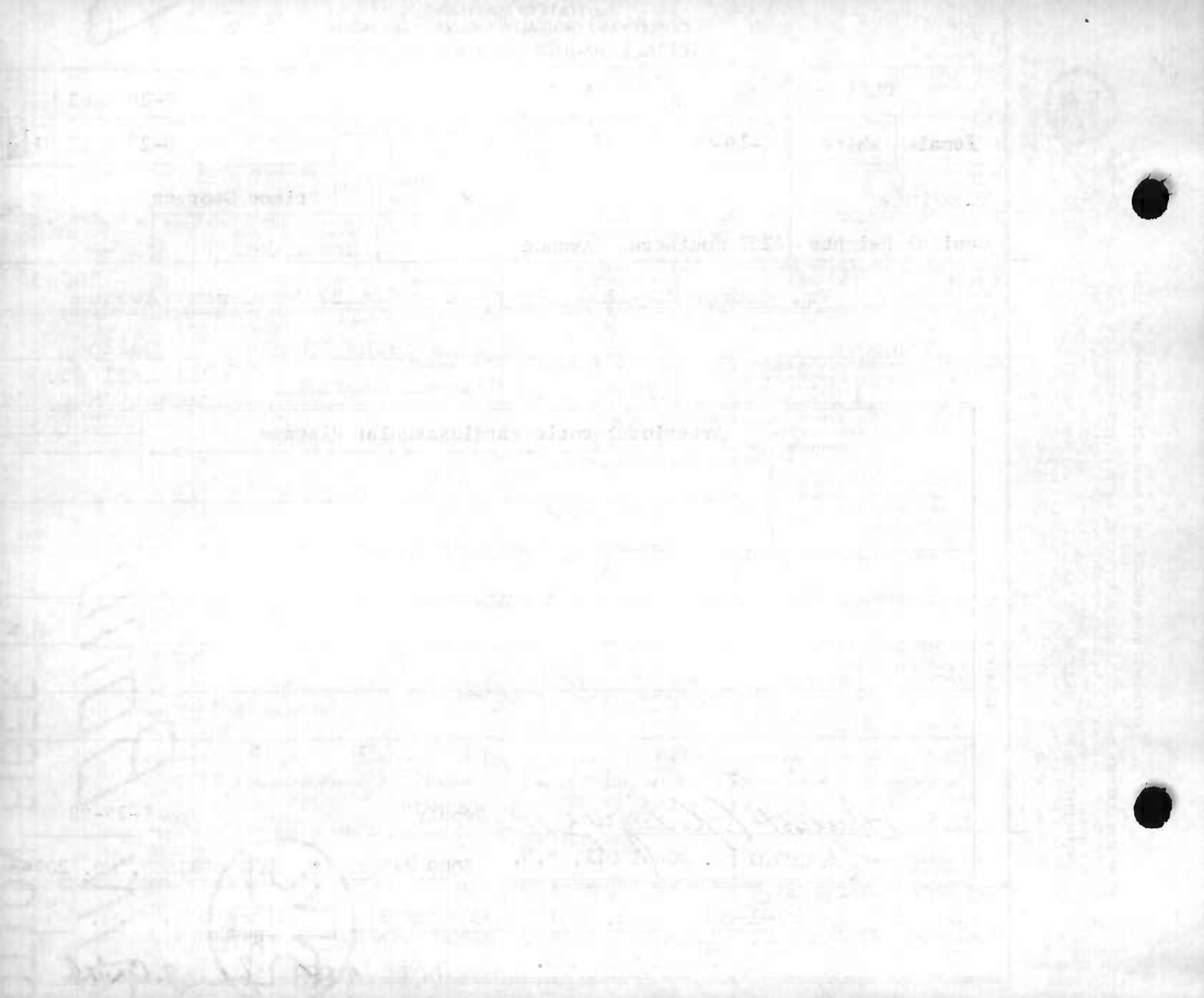
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25271

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|---|------------------------|---|-----------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) OLGA J. VANNI | | 20. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 9-29 YEAR 1983 | | 26. HOUR M 15 |
| 3 SEX female | 4 RACE white | 5. DATE OF BIRTH MONTH 3-19 DAY 08 YEAR | 6 AGE (IN YEARS) YRS. 75 | IF UNDER 1 YR. MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH Capital Heights | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4237 Southern Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker |
| 13a. STATE Maryland | | 13b. COUNTY Pr. George | | 13c. CITY OR TOWN Capital Hts |
| 14. FATHER'S NAME FIRST MIDDLE LAST Vincent Vanni | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elisabetta Maria Gallo | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-40-1910 | | 17. INFORMANT ADDRESS Silvana Cipriani 4311 Rail St. Bradbury Hts, Md |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. HOSPITAL FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | TITLE (SPECIFY) Deputy | | DATE SIGNED 9-29-83 |
| EXAMINER'S NAME (TYPE OR PRINT) AUGUSTO P. RODRIGUEZ, M.D. | | ADDRESS 5009 RABURN CT, CAMP SPRINGS, MD. 20748 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 10-1-83 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. OLIVET CEMETERY |
| 24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home | | 25a. DATE REC'D. BY REGISTRAR OCT 4 1983 | | 25b. REGISTRAR'S SIGNATURE John J. C... |
| ADDRESS Suitland, MD. | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|--|---|---|---|
| 1. FOR STATE REGISTRAR | | 25272 | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST HELEN M VISHNER | | MONTH DAY YEAR HOUR 09 03 83 11:05 am | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| Female | Caucasian | MONTH DAY YEAR January 26, 1916 | 67 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Pennsylvania | U.S.A. | | PRINCE GEORGES COUNTY MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |
| CLINTON | SOUTHERN MARYLAND HOSPITAL CENTER | | L.P.N. |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | |
| Nursing | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? |
| Maryland | Charles | Waldorf | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS |
| FIRST MIDDLE LAST Stanley Veruevski | FIRST MIDDLE LAST Elizabeth Donas | | 303 Oak Drive 20601 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS | |
| No | N/A | Ed Skodzinski - Same As #13 A-E | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER COLON WITH METASTASES</u> 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>AZOTEMIA / RENAL FAILURE</u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>9/2</u> 19 <u>83</u> <u>8/6</u> 19 <u>83</u> , to <u>9/3</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/2</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22c. DATE SIGNED |
| 22b. SIGNATURE <u>P. Wisotsky</u> M.D. | | | 22c. DATE SIGNED 9-3-83 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS |
| P. WISOTSKY M.D. | | | 6188 OXON Hill Rd. |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Cremation | September 7, 1983 | Lee's Crematory | Clinton, Prince George's, MD |
| 24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. Old Alexander Ferry Road, Clinton, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 9 1983 | |
| | | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u> | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



THE UNIVERSITY OF CHICAGO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 25273 | |
|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) MARIE C. WALDMANN | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1, 1983 | |
| 3. SEX Female | | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 6, 1909 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Laurel | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LARUEL BELTSVILLE HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD. | |
| 13a. STATE Maryland | | | 13b. COUNTY P.G. Co. | | 13c. CITY OR TOWN Laurel | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas A. Carnes | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Harrie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-16-7779 | | 17. INFORMANT ADDRESS Carl F. Waldmann same as #13c | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAPITAL ARREST / Respiratory Arrest</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>83</u> , to <u>9-1</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>8/31</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE W. A. Warren | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9/1/83 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. Warren | | 22e. ADDRESS 301 Prince George St Laurel 20707 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/1/83 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory | | 23d. LOCATION Alexandria, Va. STATE |
| 24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | 25a. DATE REC'D. BY REGISTRAR SEP 6 1983 | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Daniel John Wagner | | 2a. DATE OF DEATH MONTH DAY YEAR September 29, 1983 | | 2b. HOUR 9:55A M | |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 23, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | |
| 10. CITY OR TOWN OF DEATH Laurel | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Produce |
| 13a. STATE Maryland | | 13b. CITY Prince Georges | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE 3803 Poe Court 20716 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Wagner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille Inzeo | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WW II 063-22-1621 | | 17. INFORMANT Theresa Dominici | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HYPOTENSION</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atrial Flutter, Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Severe Peripheral Vascular disease, Diabetes Mellitus, Cirrhosis of liver</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>9-14</u> , 19 <u>83</u> , to <u>9-29</u> , 19 <u>83</u> , that (I) <u>we</u> last saw the deceased alive on <u>9-29</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>R. Arora</u> | | DEGREE MD | | 22c. DATE SIGNED 9/29/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAKESH ARORA | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Oct. 3 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland | | 23e. DATE REC'D. BY REGISTRAR OCT 3 - 1983 | | 23f. REGISTRAR'S SIGNATURE <u>John J. Lauer</u> | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home | | 16000 Annapolis Road ADDRESS Bowie, Maryland | | | |

BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|--|--|--|--|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) HELEN LOUISE WALKER | | | 2a. DATE OF DEATH MONTH DAY YEAR 09-08-83 | | 2b. HOUR 2:00AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 7, 1926 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.G.G.H. NURSING CARE CENTER | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stenographer | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 13. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alson Woodward | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Ross | | 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland P.G. Beltsville | | |
| 17. INFORMANT ADDRESS 100 Box 175 Taylors Island, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4310 DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Prolonged Coma due to Massive I.C. bleed. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) hypertension | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/31 19 82 to 9/8/83 19 83 , that (I) (we) last saw the deceased alive on 9/29/83 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Myerand, VMD | | DEGREE MD | | 22c. DATE SIGNED 9/8/83 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERARD | | 22e. ADDRESS 7100 Balt Ave Coll Pk Md 20740 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL REC'D Burial | | 23b. DATE 9/16/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland | | 23e. DATE REC'D. BY REGISTRAR SEP 19 1983 | | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. | | 25. REGISTRAR'S SIGNATURE John J. Conish | | | | |
| 26. ADDRESS Hyattsville, Maryland | | | | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25276 | |
|--|---------------|--|---|--|-----------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) LEE Marshall WALKER | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9 17 1983 | | 2b. HOUR 5:05 a.m. | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 26, 1956 27 YRS. | 6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 9 17 1983 | | 7d. HOUR 5:05 a.m. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Systems Analyst | | 12b. KIND OF BUSINESS OR INDUSTRY Computer | | | |
| 13a. STATE Maryland | | | | | | | | | | 13b. CITY OR TOWN Prince Georges Camp Springs | |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13d. STREET ADDRESS 6603 Howie Ct. 20748 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Rufus Lavern Walker | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Peggy Carawan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | (IF YES, GIVE WAR OR DATES) U.S. Navy | | 16b. SOCIAL SECURITY NO. 243-02-3962 | | 17. INFORMANT (Mother) 324 ADDRESS 14th 27889 Peggy Carawan Washington, N.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mechanical asphyxia 8160 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:20 a.m. 9-17- 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto that lost control & was pinned. | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6600 blk. Old Branch Ave., Prince George's Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 9-17-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/20/83 | | 23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington Beaufort N.C. | | | | | |
| 24. FUNERAL DIRECTOR NAME E. Barnes ADDRESS 21018 Fleming Funeral Service Benson, Md. | | | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1983 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

10-10-41

Mr. J. Edgar Hoover

Washington, D.C.

Dear Mr. Hoover:

I am writing you to inform you that I have received your letter of October 10, 1941, regarding the matter of the

U.S. Navy Department, and I am sorry that I cannot give you a more definite answer at this time. The matter is being handled by the appropriate authorities and I will be sure to advise you as soon as a final decision has been reached.

Sincerely,

10-10-41



U.S. Navy Department
Washington, D.C.

REG. NO.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
TO FUNERAL DIRECTOR: PAGE 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, DIVISION OF HEALTH AND MENTAL HYGIENE,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP_____

DHMH - 17
(VR A15 ME (5))
20M 4/B2



Private Property

1000 10th Avenue

1000 10th Avenue

1000 10th Avenue

1000 10th Avenue

1000 10th Avenue

1000 10th Avenue



1000 10th Avenue

1000 10th Avenue

1000 10th Avenue

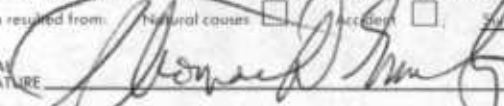

1000 10th Avenue

1000 10th Avenue

1000 10th Avenue

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 1 AND 2 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRES. BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 25278 | | REG. NO. | |
|---|--|----------------------|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) George R. Warner | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 9 12 1983 | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR July 6, 1949 | | 6. AGE (IN YEARS) BIRTHDAY YRS. 34 | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. X | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 12 1983 | | 7d. HOUR P M 5:50 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. | |
| 10. CITY OR TOWN OF DEATH Upper Marlboro | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12305 Chesterton Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Active Duty | | 12b. KIND OF BUSINESS OR INDUSTRY US Air Force | | | |
| 13a. STATE Md. | | 13b. COUNTY PG | | 13c. CITY OR TOWN Upper Marlboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 12305 Chesterton Drive | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George F. Warner | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathleen Northan | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 230-60-9932 | | 17. INFORMANT ADDRESS Celia C. Warner; 12305 Chesterton Dr. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9550 IMMEDIATE CAUSE (a) Gunshot wound of chest (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 9 12 1983 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION FIRST STREET CITY OR TOWN COUNTY STATE 12305 Chesterton Dr. Upper Marlboro P.G., MD. | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | | | TITLE (SPECIFY) Deputy Chief | | MEDICAL EXAMINER DATE SIGNED 9/13/83 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-16-83 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va. | | | | | |
| 24. FUNERAL DIRECTOR Marshall's Funeral Home 4217 9th St NW: Washington, D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25279

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 9 13 83 | | 12 ⁵ AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | Caucasian | | MONTH DAY YEAR | | 81 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Prince George's County MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Greenbelt | | Greenbelt Nursing Center | | Farmer | | Agriculture | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Maryland | | Charles Waldorf | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Box 123, Terrace Drive 20601 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Joseph Arthur | | Lillian Nevitt | | No | | 217-44-3529 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Betty Maddox | | - Box 123 Terrace Dr. Waldorf Md. | | 2500 IMMEDIATE CAUSE (a) Cerebral vascular thrombosis | | 2 days | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (b) cerebral atherosclerosis | | 2 yrs | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) aortic aneurysm | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: aortic aneurysm heart disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 19 1982 to Sept 13 1983, that (I) (we) lost the deceased alive on Sept 12 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Dr. Till Bergemann | | MD | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | |
| Dr. Till Bergemann | | 20770 Greenbelt, Md. Greenbelt Prof. Bldg., Centerway, | | SEP 19 1983 | | J. L. L. L. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 9-16-1983 | | St. Joseph's Church | | Pomfret, Charles, Md. | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | | 24d. REGISTRAR'S SIGNATURE | |
| Huntt Funeral Home, Waldorf, Maryland | | | | SEP 19 1983 | | J. L. L. L. | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25280

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Stella Mary Wessel</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>9 27 83</i> | | 2b. HOUR <i>6:30P M</i> | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Caucasian</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>July 16 1929</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>54</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Adelphi</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2603 Muskogee Street</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Pr. Geo.</i> | | 13c. CITY OR TOWN <i>Adelphi</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Alexander Pr. Geo. Rak</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha Szymanski</i> | | 13e. STREET ADDRESS / ZIP CODE <i>2603 Muskogee Street 20783</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>165-24-9224</i> | | 17. INFORMANT <i>Thomas J. Wessel</i> | | 17. ADDRESS <i>Husband Same as 13</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>1749 IMMEDIATE CAUSE (a) Metastatic Breast Cancer with</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr -</i> | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b) central nervous system involvement</i> | | | | | | <i>1 yr</i> | |
| DUE TO, OR AS A CONSEQUENCE OF <i>(c)</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/1</i> 19 <i>83</i> , to <i>9/27</i> 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>9/20</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Michael Berard, MD</i> | | | | DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED <i>9/27/83</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael Berard</i> | | | | 22e. ADDRESS <i>7100 Baltimore Ave College Park, Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>Sept. 30, 1983</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>OCT 3 1983</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i> | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED
JAN 10 1964

COMMUNICATIONS SECTION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 25231 | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lucille L. White | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 24, 1983 | | | | 2b. HOUR 10:25P M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital | | | | 12a. USUAL OCCUPATION (ITY NOT WORK FOR MOST OF WORKING LEE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. CITY OR TOWN Prince Geo. Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS - ZIP CODE 3606 Hamilton Street 20782 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel J. Crouch | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iva E. Higdon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 577 01 0245 | | 17. INFORMANT Hugh A. White | | | | ADDRESS Same as #13 (Husband) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis with Cachexia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Hypothyroidism Lt. Mastectomy</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 19</u> , 19 <u>83</u> , to <u>Sept. 24</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>August 10</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Tung P. Lee</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Tung P. Lee, MD</u> | | | | 22e. ADDRESS <u>7411 Riggs Rd Hyattsville, Md 20783</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 9/28/83 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | | | 23d. LOCATION Brentwood P.G. County Maryland | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Md. 20781 | | | | | | 25a. DATE REC'D. BY REGISTRAR SEP 27 1983 | | 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u> | | | |

BP

13 FEB 1951

Normal

White

Feb. 7, 1951

Virginia

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Feb. 7, 1951

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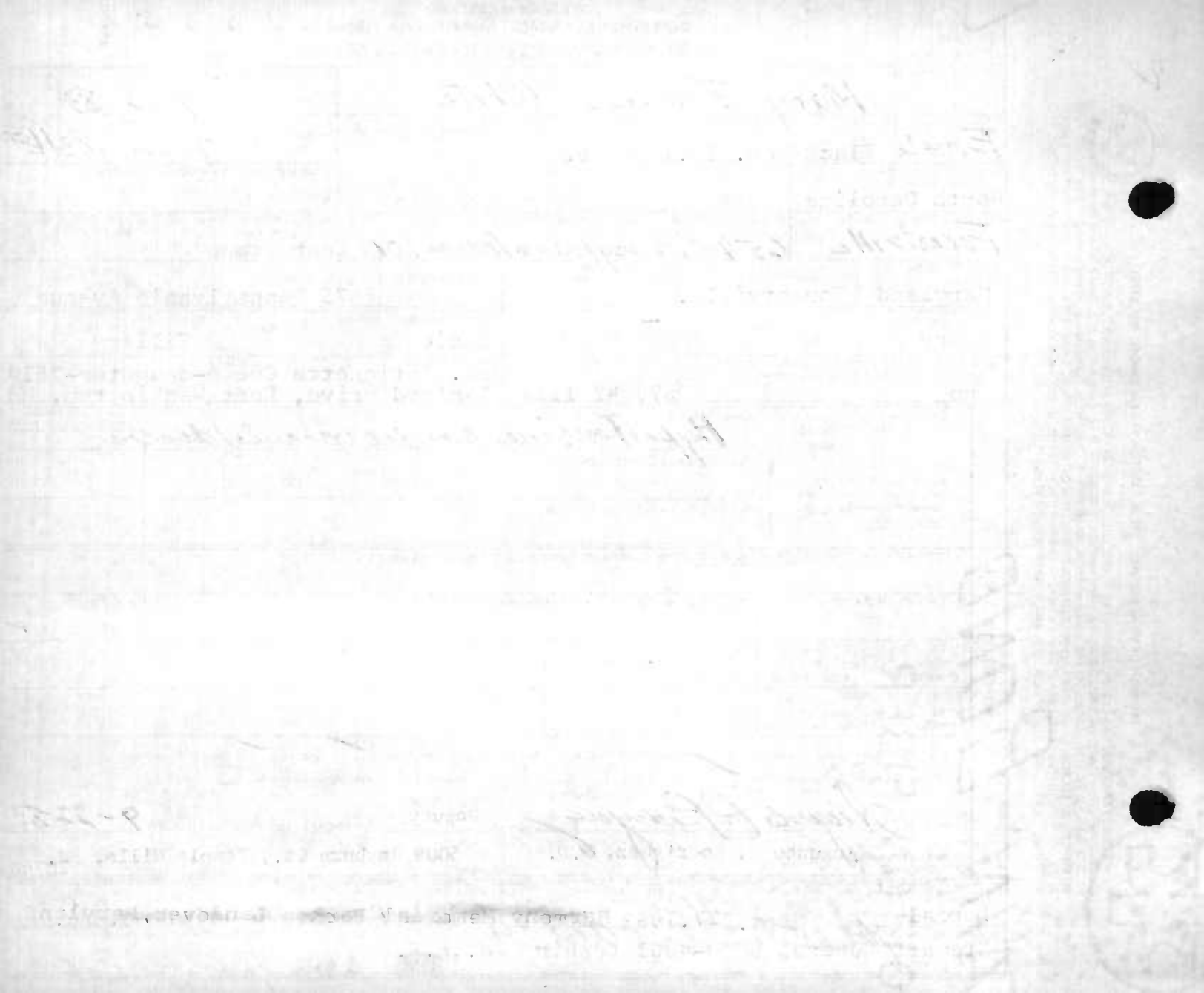
BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/B2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25282 | |
|--|-------------------------|---|--|---|--|--|-----------------------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mary Frances White | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9-22 1983 | | 2b. HOUR M 11 AM | | | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1920 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 62 RS. | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-22 1983 | 7d. HOUR M 11 AM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PG | | | | | |
| 10. CITY OR TOWN OF DEATH Forestville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6575 Pennsylvania Avenue 101 | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Char Woman | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Forestville | | 13c. CITY OR TOWN PG | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6575 Pennsylvania Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Jackson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucie Tillery | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 579 42 1127 | | 17. INFORMANT ADDRESS Mrs. Antionette Crews-daughter-7510 Blanford Drive, Fort Washington, Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiac vascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 9-22-83 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md 20748 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Sep. 27, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland | | | |
| 24. FUNERAL DIRECTOR Stewart Funeral Home | | | | 24b. DATE REC'D. BY REGISTRAR 4 1983 | | | | 25. REGISTRAR'S SIGNATURE John J. Grief | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

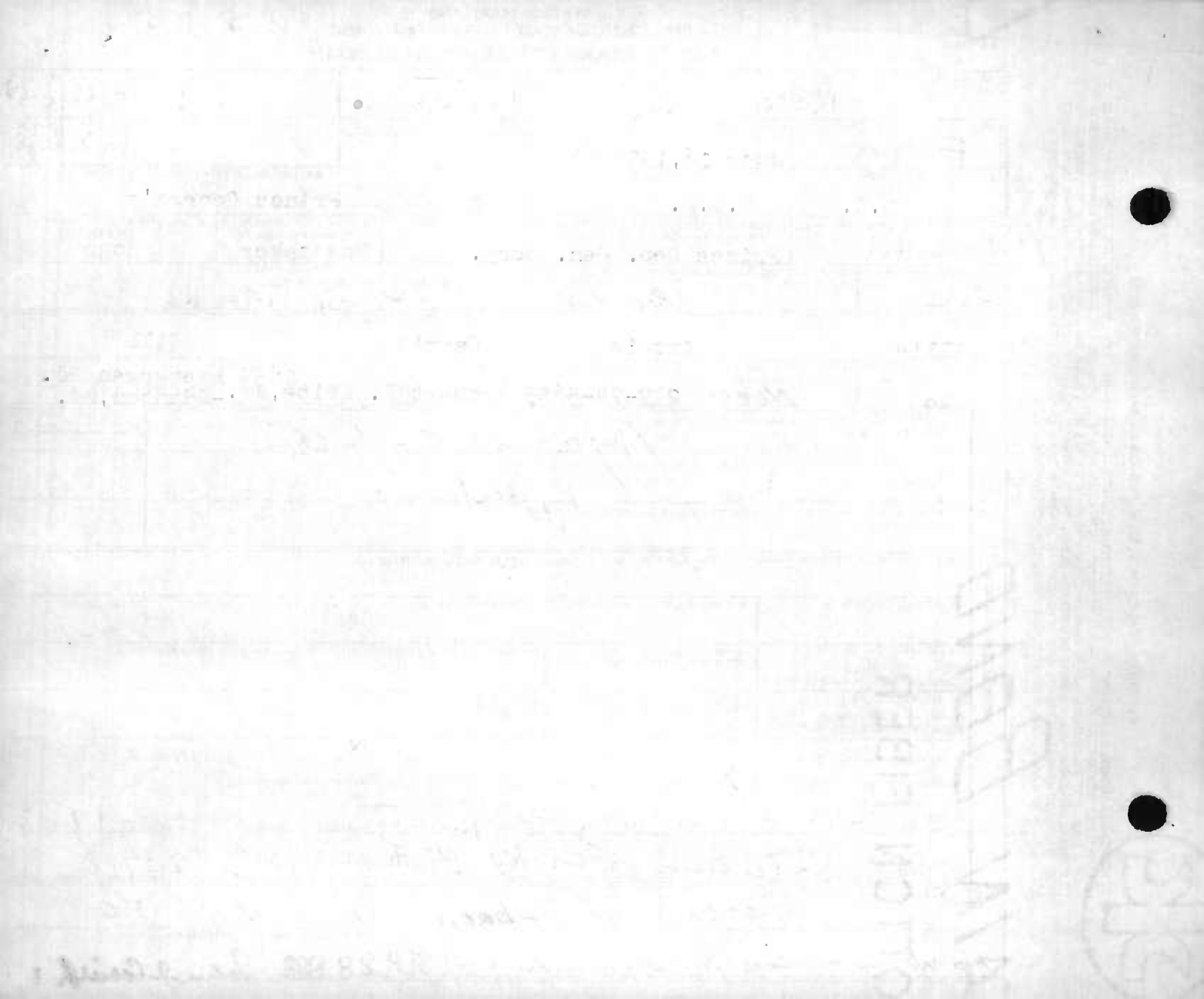
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25283

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-------------------------------------|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--------------------------------|--|--------------------------------|--|--|--|-------------------------------------|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|---|--|--------------------------------|--|--------------------------------|--|--------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | 2b. DATE ESTI- MATED | | 2c. DATE PRONOUNCED DEAD | | 2d. DATE PRONOUNCED DEAD | | 2e. DATE PRONOUNCED DEAD | | 2f. DATE PRONOUNCED DEAD | | 2g. DATE PRONOUNCED DEAD | | 2h. DATE PRONOUNCED DEAD | | 2i. DATE PRONOUNCED DEAD | | 2j. DATE PRONOUNCED DEAD | | 2k. DATE PRONOUNCED DEAD | | 2l. DATE PRONOUNCED DEAD | | 2m. DATE PRONOUNCED DEAD | | 2n. DATE PRONOUNCED DEAD | | 2o. DATE PRONOUNCED DEAD | | 2p. DATE PRONOUNCED DEAD | | 2q. DATE PRONOUNCED DEAD | | 2r. DATE PRONOUNCED DEAD | | 2s. DATE PRONOUNCED DEAD | | 2t. DATE PRONOUNCED DEAD | | 2u. DATE PRONOUNCED DEAD | | 2v. DATE PRONOUNCED DEAD | | 2w. DATE PRONOUNCED DEAD | | 2x. DATE PRONOUNCED DEAD | | 2y. DATE PRONOUNCED DEAD | | 2z. DATE PRONOUNCED DEAD | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR June 16, 1905 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 78 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's | | 10. CITY OR TOWN OF DEATH Rock Hill | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Prince Geo. Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | 13a. STATE S.C. | | 13b. COUNTY Rock Hill | | 13c. CITY OR TOWN Rock Hill | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 636 Paten Rd | | 14. FATHER'S NAME FIRST MIDDLE LAST Willie Arthie | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Gill | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Robert L. White, Jr. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | ACTUAL SIGNATURE SAID A. DASEN | | TITLE (SPECIFY) M.D. Deputy | | DATE SIGNED 9-17-83 | | EXAMINER'S NAME (TYPE OR PRINT) 5632 annapolis Rd | | ADDRESS Bladensburg MD 20710 | | 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE 9-22-83 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Hebron | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hill S.C. | | 24. FUNERAL DIRECTOR NAME H.S. WASHINGTON & SONS | | ADDRESS 4925 BURROUGHS AVE, N.E. | | 25a. DATE REC'D. BY REGISTRAR SEP 28 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 25284 | |
|---|--|----------------------|---|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) XXXXXXXX COMILLA WILLIAMS | | | | | | 2a. DATE KNOWN OF DEATH MONTH 9 DAY 27 YEAR 1983 | | 2b. HOUR 9:30 | | 2c. DATE PRONOUNCED DEAD MONTH 9 DAY 27 YEAR 1983 | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH 3 DAY 24 YEAR 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2d. DATE PRONOUNCED DEAD MONTH 9 DAY 27 YEAR 1983 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD. | | |
| 10. CITY OR TOWN OF DEATH Capitol Heights | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1320 Dunbar Oaks Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| 13a. STATE MD | | | | | | 13b. CITY OR TOWN Prince Georges | | 13c. CITY OR TOWN Capitol Hts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Willie MIDDLE C. LAST Cannady | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Estella MIDDLE LAST Robinson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 578-26-4907 | | 17. INFORMANT Willie Williams | | | ADDRESS 1320 Dunbar Oaks Dr Capitol Heights, MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease 4292 IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 9/27/1983 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 10/1/83 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland National Park | | | 23d. LOCATION CITY OR TOWN Laurel COUNTY Prince George's STATE MD | | |
| 24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019 | | | | | | 25a. DATE REC'D. BY REGISTRAR OCT 03 1983 | | | | | |

ROLLINS FUNERAL HOME, INC.
4330 HUNT PLACE, N.E.
WASHINGTON, D.C. 20019

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EUGENE WILLS | | | 2a. DATE OF DEATH MONTH DAY YEAR 09 06 83 | | | 2b. HOUR 11:25AM | | | | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 5 29 17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD. | | | | |
| 10. CITY OR TOWN OF DEATH CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Upper Marlboro | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4004 Bishop Mills Dr. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Wills | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Priscilla Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 219-16-1230 | | 17. INFORMANT ADDRESS Roberta Wills-Upper Marlboro, Md. 20772 | | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Transitional Cell Carcinoma of the Right renal pelvis with lung metastases**
1899
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 824 82 Sept 21, 1983 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-6-83 , to Sept 21, 1983 , that (I) (we) lost saw the deceased alive on 9-6-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Kai-Yin Young, MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 9-7-83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Young, MD | | | | 22e. ADDRESS 6525 Belcrest Rd #460 Hyattsville, MD 20782 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9/10/83 | | 23c. NAME OF CEMETERY OR CREMATORIUM So. Mem. Garden | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dunkirk, Calvert Md. | |

24. FUNERAL DIRECTOR NAME **Leroy E. Berry** ADDRESS **Huntingtown, Md.**25a. DATE REC'D. BY REGISTRAR **SEP 14 1983** 25b. REGISTRAR'S SIGNATURE **Joan G. Carney**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

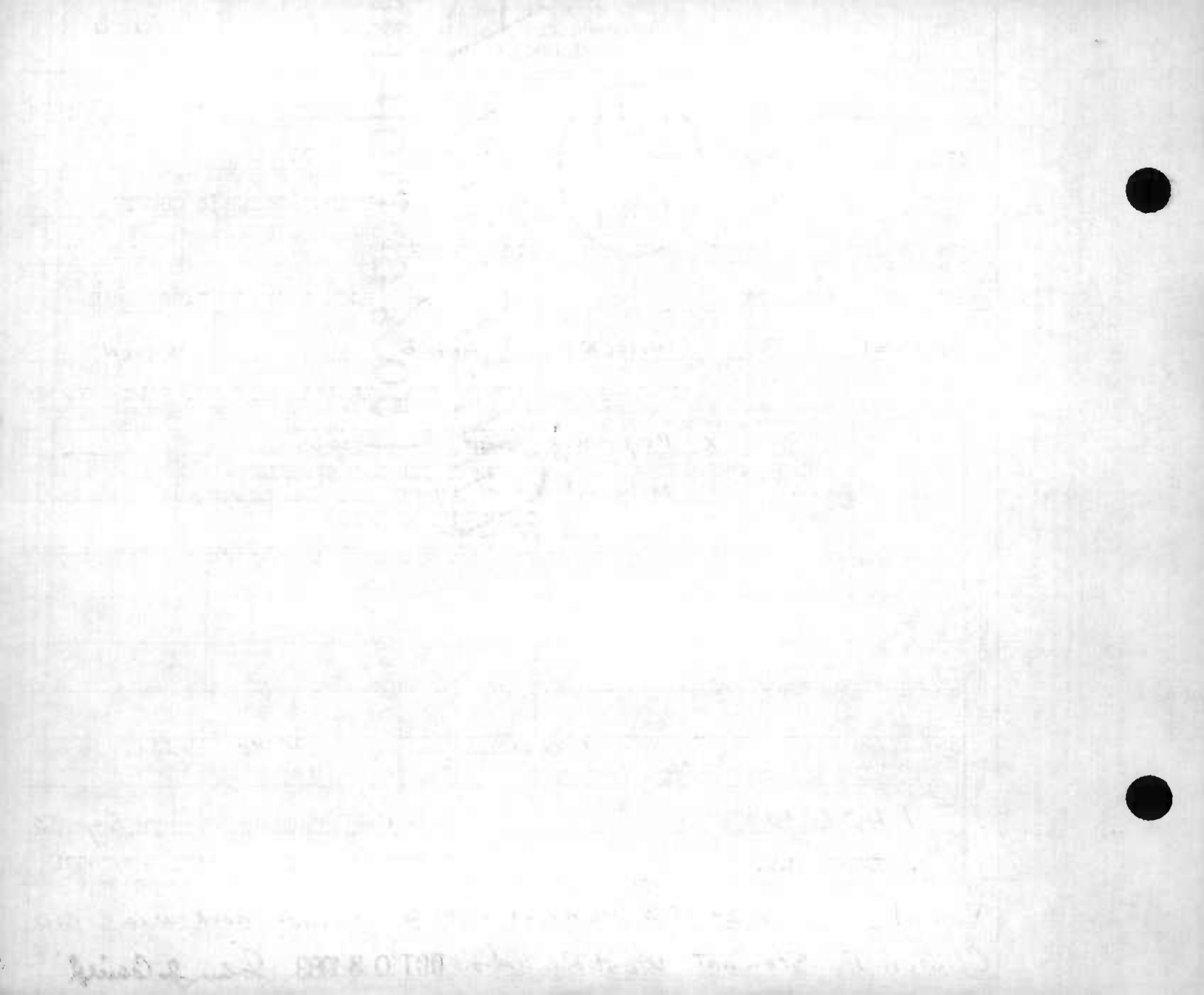
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be retained by the funeral director or the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of and

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 2 5 2 8 6 | |
|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST BOOKER WILSON | | | | MONTH DAY YEAR SEPTEMBER 20, 1983 | |
| 3 SEX MALE | | | | 2b. HOUR 10:02am | |
| 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 31 1909 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10 CITY OR TOWN OF DEATH ANDREWS AFB | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER | | 9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILITARY | | 12b. KIND OF BUSINESS OR INDUSTRY MILITARY | | 13a. STREET ADDRESS ROCK A WALKIN RIDGE ROAD | |
| 13a. STATE MARYLAND | | 13b. COUNTY SALSBURY | | 13c. CITY OR TOWN WIC | |
| 14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL B. Wilson | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE Wilson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES | |
| 16b. SOCIAL SECURITY NO. 215-14-3830 | | 17 INFORMANT TAI HO MITCHELL | | ADDRESS 104 PERRY DR. SALSBURY, MD | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) X Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF MALIGNANT PLEURAL EFFUSION (b) Malignant Pleural Effusion DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF COLON (c) Carcinoma of Colon | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 20. I certify that (I) (this hospital) attended the deceased from 1 Sep 83 , 19 83 , to 20 Sep , 19 83 , that (I) (we) last saw the deceased alive on 20 Sep , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 21. SIGNATURE P. Hindel MD | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 20 Sep 83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. HINDEL, M.D. | | 22e. ADDRESS MALCOLM GROW USAF MED CEN AAFB, MD 20331 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 9-24-83 | | 23c. NAME OF CEMETERY OR CREMATORY Head of Creek | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Head of Creek Wic MD | | 24. FUNERAL DIRECTOR NAME ADDRESS Clinton F. Stewart West Rd. Sals. Md. | | | |
| 25a. DATE RECD. BY REGISTRAR OCT 03 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Canine | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARRIOTT JOHN WINCHESTER | | | 2a. DATE OF DEATH MONTH DAY YEAR September 8, 1983 | | | 2b. HOUR 8:50a M | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR August 12, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | |
| 10. CITY OR TOWN OF DEATH LANHAM | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. Co. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Printing | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince Georges 13c. CITY OR TOWN Bowie | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3402 Maplebluff Lane 20715 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Guy J. Winchester | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Marriott | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-05-1741A | | 17. INFORMANT ADDRESS Marie W. Winchester same as 13e | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiac arrhythmias**4279**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

abdominal aortic aneurysm

DUE TO, OR AS A CONSEQUENCE OF

(c)

colon carcinomaAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>8/19</u> 19 <u>83</u> , to <u>9/8</u> 19 <u>83</u> , that (I) <u>have</u> lost saw the deceased alive on <u>9-8</u> 19 <u>83</u> and that (I) <u>was</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE R. Dakheel | | DEGREE MD | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN | | 22c. DATE SIGNED 9/18/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Riad AL-Dakheel M.D. | | 22e. ADDRESS 14300 Gallant Fox Ln, Bowie, M.D. 20715 | | | | | |

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Sept 12 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home | | ADDRESS 16000 Annapolis Road Bowie, Maryland | | 25a. DATE REC'D. BY REGISTRAR SEP 21 1983 | | 25b. REGISTRAR'S SIGNATURE John J. Chish | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| FOR 1- STATE REGISTRAR | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ELIZABETH C. WINES | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 04, 1983 | | | 2b. HOUR 4:45 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 8, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. Co. | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 325 Thomas Dr. Apt 1 20707 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James W. Merson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Duvall | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-16-0150 | | 17. INFORMANT ADDRESS Joseph M. Wines same as #13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO - RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE PULMONARY INFILTRATES</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>POSSIBLE METASTATIC LUNG DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>1629</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>PANCYTOPENIA SEVERE EMACIATION AND WEIGHT LOSS</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> 19 <u>83</u> , to <u>9/4</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/4</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SYED A. SADIQ</u> | | | | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>9/4/83</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u> | | 23b. DATE <u>9/7/83</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Laurel, P.G.Co. Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>FLECK FUNERAL HOME, INC.</u> 7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | | | 25a. DATE REC'D. BY REGISTRAR <u>SEP 6 1983</u> | | 25. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

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[Faint, illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Barbara Elizabeth Witchoski | | | 2a. DATE OF DEATH MONTH DAY YEAR September 17, 83 | | | 2b. HOUR 4 ³⁰ P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 15, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George Co. MD. | |
| 10. CITY OR TOWN OF DEATH Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6911 Redmiles Rd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Virginia | | 13b. COUNTY Arlington | | 13c. CITY OR TOWN Arlington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Barney B. Hall | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha J. Maxwell | | 13e. STREET ADDRESS / ZIP CODE 1913 N. Vance St. 22201 | | 99999 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-20-2145 | | 17. INFORMANT ADDRESS Joseph M. Witchoski same as #13 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

2089 IMMEDIATE CAUSE (a) Leukemia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 17, 19 83</u> , to <u> </u> , 19 <u> </u> , that (if two) lost saw the deceased alive on <u>SEPT 17, 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If not, (I) (we) did not view the body after death). | | | | | | | |
| 22b. SIGNATURE <u>Bruce W. Gattis</u> | | | | DEGREE MD | | 22c. DATE SIGNED 9/17/83 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE W. GATTIS | | | | 22e. ADDRESS 14333 LAUREL-BOWIE RD. SUITE 202 LAUREL, MD 20708 | | | |

| | | | | | | | |
|---|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 9/18/83 | | 23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | 25. DATE REC'D BY REGISTRAR / REGISTRAR'S SIGNATURE SEP 19 1983 <u>John J. Carroll</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or the medical examiner's office must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---------------------|
| 1. FOR STATE REGISTRAR | | 25290 | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES HANWAY WOLFE, Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 2 1983 | | | | | 2b. HOUR 2:50P M |
| 3. SEX MALE | | 4. RACE CAUCASION | | 5. DATE OF BIRTH MONTH DAY YEAR JANUARY 26 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD. | | | | |
| 10. CITY OR TOWN OF DEATH AAF B Camp Springs | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow USAF Med Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Military | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE | | 13b. COUNTY ✓ | | 13c. CITY OR TOWN Wash., D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2810 31st Street, S.E. 99999 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Wolfe, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Dych | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WWII-Korean 579-40-6901 | | 17. INFORMANT ADDRESS Irma Wolfe / Wife Same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2041 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>LEUKEMIA</u> (b) <u>chronic lymphocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF <u>squamous cell carcinoma of the lung</u> (c) <u>squamous cell carcinoma of the lung</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1 SEPT</u> , 19 <u>83</u> , to <u>2 SEPT</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>2 SEPT</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Beth Haselhorst MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 2 Sept 83 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BETH HASELHORST, CAPT, USAF, MC | | 22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER AAFB MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6Sept1983 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md. | | | | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home | | | | 25a. DATE REC'D BY REGISTRAR SEP 13 1983 | | REGISTRAR'S SIGNATURE John J. Conner | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

25291

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|---|--|---|
| 1 DECEASED NAME (TYPE OR PRINT) James C. Wood | | | 2a. DATE OF DEATH MONTH DAY YEAR Sept. 29, 1983 | | 2b. HOUR 8:05 AM |
| 3 SEX Male | 4 RACE Caucasian | 5 DATE OF BIRTH MONTH DAY YEAR Jan. 31 1907 | 6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD. | | |
| 10 CITY OR TOWN OF DEATH Laurel | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Grtr. Laurel Beltsville Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Mang. | 12b. KIND OF BUSINESS OR INDUSTRY Auto | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY P.G. | 13c. CITY OR TOWN Laurel | 13d. STREET ADDRESS 14107 Clarke Ave. 20707 |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles C. Wood | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mayhew | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | 17 INFORMANT 8404 Holly Str. Joseph Wood Laurel, Md. 20707 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST.</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY HEART DISEASE.</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> , 19 <u>83</u> , to <u>9-29</u> , 19 <u>83</u> , that (I) (we) last <input checked="" type="checkbox"/> saw the deceased alive on <u>9-28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>M. G. CHANDLER</u> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. G. CHANDLER, MD | | 22e. ADDRESS 14201 Laurel Pike Drive #600 Laurel Md. 20707 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1 Oct 83 | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Md. |
| 24 FUNERAL DIRECTOR NAME FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. | | | 25a. DATE REC'D. BY REGISTRAR SEP 30 1983 | | |
| | | | 25b. REGISTRAR'S SIGNATURE <u>Samuel G. Goid</u> | | |

General Hospital
Cantonment
Cantonment

2-12-23

W. H. Campbell, Jr.
Cantonment

Medical Examiner Notified & Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|--|---|--|---|---|--|
| # 15-16, Film C585 11/10/83 kam | | | | | 25292 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Prince Wellington Wright | | | | | 2a. DATE OF DEATH MONTH DAY YEAR September 3, 1983 | |
| 3. SEX Male | | | | | 2b. HOUR 3:40P.M. | |
| 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR March 12, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD. | | | | | 10. CITY OR TOWN OF DEATH Riverdale | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Counselor | |
| 12b. KIND OF BUSINESS OR INDUSTRY Veterans Administration | | | | | 13a. STREET ADDRESS 5309 Hamilton Street #2 | |
| 13b. CITY OR TOWN Hyattsville | | | | | 13c. ZIP CODE 20781 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown Bismark Wright | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Rosetta | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Navy | | | | | 16b. SOCIAL SECURITY NO. 231-20-2736 | |
| 17. INFORMANT Lois L. Bond | | | | | ADDRESS Address Same as No# 13e. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1979 to 9/3 , 19 83 , that (I) (we) lost the deceased on 8/31 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE John R. Melnick DEGREE | | | | 22c. DATE SIGNED Sept. 6, 1983 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick, M.D. | | | | 22e. ADDRESS 16220 Frederick Road Gaithersburg, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Sept. 7, 1983 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory Brentwood | | |
| 23d. LOCATION CITY OR TOWN P.G. Maryland | | | | | | |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR SEP 8 1983 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Carter | | |

BP

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7584 mtl 10/6/83 Items 1,5, & 6
 1- FOR
 STATE
 REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 REG. NO. 25293

| | | | | | |
|---|-----------------------------|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM T. YODERS | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 9 DAY 15 YEAR 1983 | | 2b. HOUR AM 1:48 PM P. |
| 1. SEX male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH 4 DAY 8 YEAR 1910 | 6. AGE (IN YEARS) 73 YRS. | IF UNDER 1 YR. MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Camp Springs | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow USAF Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Prince George | | 13c. STREET ADDRESS Ft. Washington | |
| 14. FATHER'S NAME FIRST Samuel MIDDLE Yoders LAST Yoders | | 15. MOTHER'S MAIDEN NAME FIRST Jeannie MIDDLE Mc Donna LAST Mc Donna | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | |
| 17a. SOCIAL SECURITY NO. 162-14-6826 | | 17b. INFORMANT Martha Yoders | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease (b) black lung (c) black lung | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). black lung | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | TITLE (SPECIFY) Deputy | | DATE 9/15/1983 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | ADDRESS 5009 Rayburn Ct., Temple Hills, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 9/19/83 | | 23c. NAME OF CEMETERY OR CREMATORY Lafayette Memorial | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Brownsville Pennsylvania | | 24. FUNERAL DIRECTOR George P Kalas F. H. 6160 Oxon Hill Rd Oxon Hill Maryland | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DATE REC'D. BY REGISTRAR **SEP 22 1983** REGISTRAR'S SIGNATURE **John J. Carver**

75

George Prince

Washington

George Prince

Washington

George Prince

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George Prince

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George Prince

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George Prince

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George Prince

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NOTED, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25294

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | |
|---|---------|------------------|--|---|------------------|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| MELVIN LEON YOUNG | | | | | | 9 10 19 83 | | | 9 10 19 83 | | | 12:55 aM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | | MONTH DAY YEAR | | | 2d. HOUR | | |
| Male | Black | 5 - 29 - 1933 | 50 YRS. | | | 9 10 19 83 | | | 9 10 19 83 | | | 12:55 aM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | |
| Maryland | | | USA | | | | | | P.G. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Camp Springs | | | Malcolm Grow USAF Med. Center | | | Sand Blaster | | | Sand Gravel Co | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| Md | | | P.G | | | Brandywine | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 18710 Aquasco Rd 20613 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| John Robert Young | | | Martha V Brown | | | Yes | | | 214-30-1404 | | | Ann Young SAA | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease | | | | | | | | | | | | | | |
| 4960 | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | |
| | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | |
| Augusto P. Rodriguez | | | | M.D. Deputy | | | | 9/10/1983 | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | |
| Augusto P. Rodriguez, M.D. | | | | 5009 Rayburn Ct., Temple Hills, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | |
| Burial | | | | 9-14-83 | | | | Md Veterans Cem | | | | Cheltenham P.G. Md | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Montell Adams | | | | SEP 26 1983 | | | | John J. Smith | | | | | | |

